CENEVIA
HEALTH BUSINESS SERVICES

Dental Enrollment Packet

The information requested on this form is required for the accurate completion of provider enrollment. CCNV will not begin enrollment without the required information below. Please complete ALL requested information below and return to CCNV with the application packet.

Please provide an age range of patients you will accept:
Minimum age: _____ Maximum Age: _____

Specialty:

- ☐ Advanced Dental Therapist
- ☐ Endodontist
- ☐ Dental Health Aide Therapist
- ☐ Dental Therapist
- ☐ Denturist
- ☐ General Dentist
- ☐ Oral Pathologist
- ☐ Oral Radiologist
- ☐ Oral Surgeon
- ☐ Orthodontist
- ☐ Pediatric Dentist
- ☐ Periodontist
- ☐ Prosthodontist
- ☐ Registered Dental Hygienist
- ☐ Other: _____

List current professional memberships:

- ☐ ADA
- ☐ State Dental Society
- ☐ Local Dental Society
- ☐ Other: _____

What is your practice management system? _____

Do you file claims electronically? ☐ Yes ☐ No

Is your office accessible by public transportation? ☐ Yes ☐ No

Do you have a mobile dental facility? ☐ Yes ☐ No

Do you accept Worker's Compensation patients? ☐ Yes ☐ No

Do you offer pre-paid plans? ☐ Yes ☐ No

Provide the square footage of your office. _____

Provide a list of all languages (other than English) spoken by staff in your office: _____

Provide the number of dental chairs: _____

Provide the number of fully equipped operatories in your office: _____

Is there a dental assistant present in your office during regularly scheduled hours? ☐ Yes ☐ No

Does your office have managed dental care experience? ☐ Yes ☐ No

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Provide the name and contact information for the Authorizing Dentist(s) if applicable: _____
_____

Provide the name and contact information for the Supervising Dentist(s) if applicable: _____
_____

What is your office's current daily patient load?
_____ Dentistry _____ Hygiene

What is your current maximum daily capacity as a provider?
_____ Dentistry _____ Hygiene

Provide the number of full-time at your location:
_____ Hygienists _____ Assistants
_____ Receptionists _____ Associate Dentists

Provide the number of part-time at your location:
_____ Hygienists _____ Assistants
_____ Receptionists _____ Associate Dentists

After Hours/Emergency Coverage:
- ☐ Answering Service
- ☐ Coverage by Another Office
- ☐ Answering Machine
- ☐ Other: _____
- ☐ None

This office providers (check all that apply):
☐ Nitrous Oxide ☐ Amalgam-Free ☐ X-Ray ☐ Panographic X-Ray
☐ Laboratory Services ☐ On-Site Lab Services ☐ General Anesthesia ☐ IV Sedation

What is the wait time for the following appointment types, in number of calendar days:
_____ Initial
_____ Recall
_____ Routine
_____ Adult Hygiene Visit
_____ Child Hygiene Visit
_____ Restorative Visit
_____ Reschedule of appointments

What is the wait time for Urgent appointments, in number of hours? _____

What is the in-office waiting room waiting time, in number of minutes? _____

Are all staff members trained in CPR? ☐ Yes ☐ No

What is the number of units you have available at your location:
_____ Panoramic X-Ray Units
_____ Periapical X-Ray Units
_____ Other X-Ray Units

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Please provide your ADA log in information. _____

Does your office have an emergency kit present?
If yes, please provide expiration date for the items listed below.

- Epinephrine 1:1000 (injectable) is present and not expired ☐ Yes ☐ No Expiration: _____
- Histamine blocker (injectable) is present and not expired ☐ Yes ☐ No Expiration: _____
- Nitroglycerin is present and not expired ☐ Yes ☐ No Expiration: _____
- Bronchodilator/Albuterol is present and not expired ☐ Yes ☐ No Expiration: _____
- Aspirin is present and not expired ☐ Yes ☐ No Expiration: _____
- Sugar is present ☐ Yes ☐ No

Does your office have a portable oxygen tank along with an Ambu-bag or positive pressure device available for medical emergencies that is separate from any nitrous oxide unit, maintained full, and readily available / accessible to all areas of the dental office (e.g. waiting room, hallway, bathroom, etc.)? ☐ Yes ☐ No

Is spore testing performed monthly? ☐ Yes ☐ No

Does office meet all federal and state requirements, including ADA, OSHA, CDC Infection Control recommendations?
☐ Yes ☐ No

Does your office utilize proper infection control and barrier techniques? ☐ Yes ☐ No

Are all instruments and tools heat sterilized or disposed of between patients? ☐ Yes ☐ No

Are accommodations adequate for handicapped/disabled patients or office is otherwise considered compliant under the Americans with Disabilities Act? ☐ Yes ☐ No

If yes, check all that apply:

☐ Adult	☐ Child	☐ ADHD	☐ Physically Disabled	☐ Learning Disabled
☐ HIV	☐ AIDS	☐ Paraplegic	☐ Quadriplegic	☐ Seizure Disorders
☐ Cognitive Disability		☐ Mobility Limitations	☐ Autism	☐ Communication Disorders
☐ Behavioral Disorders		☐ Hearing Impaired	☐ Visually Impaired	

Do you accept and treat patients with disabilities (including, but not limited to, HIV positive/AIDS and Hepatitis B carrier) in accordance with the requirements of the Americans with Disabilities Act and professionally recognized standards?
☐ Yes ☐ No

Are there practice limitations at this location, including patient age? ☐ Yes ☐ No

If yes, explain limitations: _____

Printed name: _____

Signature: _____ Date: _____

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Please complete **ALL** sections below. If any section is not applicable, please put "N/A." If this form is incomplete, or if it is not signed and dated, it will be returned with request for completion. Please note that this form is now required in order to complete enrollment with CCNV.

Practitioner Information

Practitioner Name: _____

Practitioner NPI: _____

Are you a PCP? ____ Yes ____ No

Employment Status ____ Full Time ____ Part Time ____ Locum

Practice Information

Current Practice Location: _____

Practice Location Address: _____

Practitioner Hours: Monday: _____. Tuesday: _____. Wednesday: _____.

Thursday: _____. Friday: _____. Saturday: _____.

Sunday: _____.

Malpractice History

Please provide **5 YEARS** of malpractice history in the space below. Dates **must** be in month/year format. If you have a copy of the malpractice certificate(s), please include a copy with this application. If you need more space, please continue on a separate sheet and include with this application.

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By my affixed signature, I, _____ (print name), do hereby attest that I am no longer employed with the entities listed below. Any and all association with said entities has been terminated on the effective date listed below.

Former Employer	Tax ID #	PCP or Specialist	Termination Date
		□ PCP □ Specialist	
		□ PCP □ Specialist	
		□ PCP □ Specialist	

By my affixed signature, I, _____ (print name), do hereby attest that I remain employed by the entities listed below.

Former Employer	Tax ID #	PCP or Specialist	Specialty
		□ PCP □ Specialist	
		□ PCP □ Specialist	
		□ PCP □ Specialist	

Printed name: _____

Signature: _____ Date: _____