Practice Summary Questionnaire

compbenefits
vision
dental

Current Practice Name: _____

Owner's Name (if different from above): _____

Contact Person/Title: _____

List any General Dentist or Specialist below who will provide services to CompBenefits members in this practice:

First/Last Name(s)	Type of Specialty	Associate or Owner	Dental License Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Number of:

Dentists: _____ Receptionists: _____

Hygienists: _____ Lab Technicians: _____

Dental Assistants: _____ Operatories: _____

Office hours:

Monday _____ to _____ Friday _____ to _____

Tuesday _____ to _____ Saturday _____ to _____

Wednesday _____ to _____ Sunday _____ to _____

Thursday _____ to _____

Do you have 24 hour emergency services? _____ If yes, explain patient instructions:

_____

_____

_____

_____

Do you have in-house specialists? If so, please check all that are applicable.

(Only list those specialists that will not be providing services to CompBenefits members.)

Endodontist	_____	Name: _____
Oral Surgeon	_____	_____
Orthodontist	_____	_____
Pediatric Dentistry	_____	_____
Periodontist	_____	_____

Languages spoken in office: English _____ Spanish _____ Other _____

Electronic claim submission capability? Yes _____ No _____

Clearinghouse used: _____

Services Provided (Check all that apply):

Pediatric Dentistry:
At what age do you treat children? _____

Extractions:
routine _____
surgical _____
impaction _____

I.V. Sedation: _____
Nitrous Oxide: _____

Orthodontics:
limited _____
full mouth _____

Panoramic X-ray:
Cephalometric: _____

Restoration:
amalgam _____
resin _____

Periodontics:
non-surgical _____
surgical _____

Endodontics:
anterior _____
bicuspid _____
molar _____

Prosthetics:
partials _____
dentures _____

Recall Syestem:
postcard _____
phone call _____
other (list) _____