DELTA DENTAL®

Individual Practitioner Profile

Complete this form in its entirety and **email it to ProviderRelations@deltadentalva.com** or fax it to 540.491.9709.

First name | Middle name | Last name | Date of birth

Other names used, if applicable

Gender: ☐ Female ☐ Male ☐ Private ☐ Nonbinary

Race/ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefer not to disclose

Virginia Dental License Number | National Provider Identifier Number (NPI)

Dentist email address

Office email address

Recredentialing email address

Dental school attended | Year of graduation

Name of specialty, if applicable | Specialty program completed | Year of graduation

Are you a Board Certified specialist? ☐ Yes ☐ No **(Certificate is required — please attach a copy)**

Do you administer any level of anesthesia other than local anesthetic or nitrous oxide sedation? ☐ Yes ☐ No **(Anesthesia Permit is required — please attach a copy)**

The American Academy of Pediatric Dentists defines special health care needs to be any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs.

Do you treat children who are intellectually disabled or have special needs? ☐ Yes ☐ No

Do you treat adults who are intellectually disabled or have special needs? ☐ Yes ☐ No

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INDIVIDUAL PRACTITIONER PROFILE (CONTINUED)

1. Have any malpractice claims or suits ever been filed against you? ☐ Yes ☐ No

2. Has your professional license in any state ever been denied, revoked, limited, suspended, put on probation or voluntarily relinquished? ☐ Yes ☐ No

3. Has your DEA permit ever been denied, revoked, limited, suspended, or voluntarily relinquished? ☐ Yes ☐ No

4. Have you ever been convicted of a criminal offense? ☐ Yes ☐ No

5. Have you ever been disciplined by a state board of dental examiners or a misconduct board? ☐ Yes ☐ No

6. Have you ever been subject to peer review action? ☐ Yes ☐ No

7. Have you ever had, or do you currently have, a chemical dependency or substance abuse condition? ☐ Yes ☐ No

8. Do you have any mental or physical condition that results in an inability to perform the essential functions of your profession, with or without accommodation? ☐ Yes ☐ No

9. Do you now or have you ever had any sanctions against you by the Office of Inspector General (OIG), Medicare and/or Medicaid? ☐ Yes ☐ No

10. Are you eligible for DEA or CDS certification? ☐ Yes ☐ No

11. If applicable, are your hospital privileges in good standing? ☐ Yes ☐ No

12. Does your office use infection control and barrier techniques according to CDC standards? ☐ Yes ☐ No

13. Does your office clean and heat sterilize high-speed, air-driven hand pieces and prophy angles after each patient? ☐ Yes ☐ No

14. Do you take initial medical/dental history with periodic updates? ☐ Yes ☐ No

15. Do you routinely use a dental or medical consent form for treatment? ☐ Yes ☐ No

If you answered "yes" to questions one through seven, please provide dates, circumstances and dispositions on a separate sheet of paper.

I hereby certify that the information provided and the answers to the questions on this profile are accurate and complete. I agree to immediately notify Delta Dental of Virginia in writing of any changes, including any changes to my professional liability insurance. I hereby give Delta Dental permission to request information from other entities regarding my professional credentials and qualifications. This release of information will not remain valid in the event the Participating Dentist Agreement is terminated.

_____ _____/_____/_____

Signature Date