FACILITY APPLICATION ***(Complete one application per facility)***

Facility Information

PRACTICE NAME (DBA): _____

PRACTICE ADDRESS: _____

Street Address *Suite/Unit #*

_____

City *State* *Zip* *County*

TELEPHONE #: ( ) _____ **Fax #:** ( ) _____

EMERGENCY #: _____ **EMAIL ADDRESS:** _____

INDIVIDUAL NPI #: _____ **ORGANIZATIONAL NPI #:** _____ *(if applicable)*

TAX PAYOR IDENTIFICATION (TIN): _____ **CONTACT NAME:** _____

MAILING ADDRESS**:** _____

(if different from above) *Street Address* *Suite/Unit #*

_____

City *State* *ZIP Code*

LANGUAGES SPOKEN: _____

RECALL METHOD USED: _____

PRIMARY DENTIST: _____ ☐**DDS** ☐ **DMD** ☐**Other (specify)** _____

ASSOCIATE DENTIST: _____ ☐**DDS** ☐ **DMD** ☐**Other (specify)** _____

ASSOCIATE DENTIST: _____ ☐**DDS** ☐ **DMD** ☐**Other (specify)** _____

ASSOCIATE DENTIST: _____ ☐**DDS** ☐ **DMD** ☐**Other (specify)** _____

(Attach list with additional Associates if necessary)

Please check if this facility is designated as any one of the following:

☐**(FQHC)** Federally Qualified Health Center

☐**(CHC)** Community Health Center

☐**(IHS)** Indian Health Services

☐**(RHC)** Rural Health Clinic

Accessibility

Does this facility have a 24 hour emergency contact system? ☐ **Yes** ☐ **No** **Special Needs** ☐ **Yes** ☐ **No**

What type of emergency contact system is used? _____

Is this facility wheelchair accessible? ☐ **Yes** ☐ **No**

Age range of patients seen? ☐ **0 – 99+** ☐ **0 – 21** **Minimum Treatment Age:** _____ ☐ **Other:** _____

Hours of Operation

Monday		AM		PM
Tuesday		AM		PM
Wednesday		AM		PM
Thursday		AM		PM
Friday		AM		PM
Saturday		AM		PM
Sunday		AM		PM

Appointment Wait Times

Initial _____ **days**

Hygiene _____ **days**

Routine _____ **days**

Lobby Wait Time _____ **minutes**