

PRACTICE INFORMATION

Practice Name _____ Phone _____ Fax _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Mailing Address (if different from above) _____ City _____ State _____ Zip Code _____

Principal Owner(s) _____ Principal Contact(s) _____ Billing Provider NPI _____

Legal Entity (*check one*) Corporation Partnership Sole Proprietor Tax ID Number (TIN) or Employer ID Number (EIN) _____

Office Staff: Dentists: Hygienists: Assistants: Receptionists: Operatories:

Foreign Languages Spoken: Cantonese Chinese Farsi Hmong Korean Mandarin
 Punjabi Russian Spanish Vietnamese Other _____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

FACILITY DETAIL

Facility Location (check one): Professional Building Stand-alone Building Shopping Center

Number of Accessible Parking Spaces: _____ Handicap Accessible? NO YES Near Public Transit? NO YES

Waiting Room Capacity: _____ Drinking Fountain? NO YES Patient Education Materials Available? NO YES

Number of Operatories: _____ Expansion Capability? NO YES Credit Cards Accepted? NO YES

Number of Standard X-Ray Machines: _____ Panorex? NO YES Digital X-Ray? NO YES

Laboratory Capacities (check all that apply): Pouring Models Minor Repairs Fabricate Dentures Fabricate Crowns

Facility uses computer(s) for (check all that apply): Practice Management Appointment Scheduling Insurance Billing (EDI)
 Accounts Receivable Computers not used

CAPACITY / AVILABILITY

Total Maximum Capacity (number of patients): _____ At what percentage of your Total Maximum Capacity are you operating? _____

Access/Appointment Availability: Initial: _____(wks) Routine: _____(wks) Hygiene: _____(wks) Emergency: _____(hrs)

Average Waiting Time in Office with Appointment: _____

AFTER-HOURS ACCESS

Does your office have an answering service or answering machine during non-business hours which provides instructions regarding how patients may obtain urgent or emergency care? NO YES