**DentaLine**
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## Provider Information Application

*Please fill out the information below to help us learn more about your practice.*

| | | |
|---|---|---|
| Doctor: | Specialty: | |
| Address: | | |
| Office Telephone: (     ) | Home Telephone: (     ) | Fax: (     ) |
| Web Site: | Email Address: | |
| Type of Practice: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Group ☐ General Dentist | | |
| Other Providers: How many associates? | How many hygienists? | |
| Please attach a list of providers and their degrees or list on the back of this form. | | |
| | | |
| Contact Person: | Title: | |
| Number of employees? | Please attach their names and positions and time with practice. | |
| How long have you been at current location? | How long have you been in practice? | |
| Hours of Operation: | | |
| Mon: to Tues: to Wed: to Thu: to Fri: to Sat: to | | |
| Do you see emergency new patients? | Protocol: | |
| | | |
| Average Total Patients Seen per Month: | Average New Patients per Month: | |
| What makes your office special? (Types of Services/Patient Comfort Amenities/Specialties/Team Friendliness) | | |
| | | |
| In-house laboratory: ☐ Yes ☐ No | Same Day Crowns: ☐ Yes ☐ No | 1 Hour Whitening: ☐ Yes ☐ No |
| College(s)/Dental School/Other Training: | Date: | Degrees/Certificates: |
| | | |
| | | |
| | | |
| Licensed to Practice: | State(s): | Date: |
| | | |
| | | |
| Has your license ever been suspended, revoked or other disciplinary action taken? ☐ Yes ☐ No | | |
| If yes, give reason and dates. Attach separate sheet if necessary. | | |
| | | |

*I verify that the above information is accurate and true. I understand that my Application is not an Agreement.*

______________________________ *AZ State License Number: ______________

Signature of Applicant

**Please attach a current copy of your Arizona State license.*