

**PROSPECTIVE PROVIDER FORM**

Legal Business Name: \_\_\_\_\_  
Clinic Name/DBA: \_\_\_\_\_  
TIN: \_\_\_\_\_ Org/Billing NPI: \_\_\_\_\_  
Owner/Provider: \_\_\_\_\_ NPI: \_\_\_\_\_  
Primary Office Contact: \_\_\_\_\_  
Office Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code+4: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
Contact E-mail: \_\_\_\_\_  
Web Address: \_\_\_\_\_

Provider Type (circle one): General Dentist    Pedo    Perio    Endo    Oral Surgeon    Denturist    EPDH  
Organization Type: Sole Proprietorship    Partnership    LLC    PC    Other: \_\_\_\_\_

**For additional clinic providers, submit a list with provider full names, degree, and NPI.**

**OFFICE HOURS:** Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_

**Community Outreach** such as delivering services in alternate setting such as schools, Head Start programs, Nursing Homes etc. requires Capitol Dental Care approval of these activities and locations as a condition of payment consideration. Are you requesting to participate in community outreach?

Yes \_\_\_ No \_\_\_ **If yes**, please explain the activity and indicate the outreach location(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will you be providing dental treatment in your office using **general anesthesia or I.V. or conscious sedation**?

Yes \_\_\_ No \_\_\_ **If yes**, have you notified the Oregon Board of Dentistry? Yes \_\_\_ No \_\_\_

Will you be administering the sedation? Yes \_\_\_ No \_\_\_ **If no**, please indicate provider administering sedation:

Is your office accepting **new patients**? Yes \_\_\_ No \_\_\_ **If no**, please identify any limitations:

Do you have patient **age limitations**? Yes \_\_\_ No \_\_\_ **If yes**, please identify limitation: \_\_\_\_\_

Will you see **special needs** patients? Yes \_\_\_ No \_\_\_ **If yes**, please identify any limitations:

\_\_\_\_\_

Does the office provide care using seclusion or restraint? Yes \_\_\_\_\_ No \_\_\_\_\_

***If yes, please provide a copy of your consent form when returning the completed credentialing packet.***

**Due to new federal regulations, we are required to include information about ADA accessibility in our provider directory regarding every office. Please complete the following information.**

Does the office have ADA accessibility, including exam rooms, restrooms and equipment? Yes \_\_\_\_\_ No \_\_\_\_\_

**Language & Communication Access:**

Does the provider speak a language other than English? Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes**, please list language(s): \_\_\_\_\_

Does the clinic staff speak a language other than English? Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes**, please list language(s): \_\_\_\_\_

**Cultural Competency Training:**

Have you completed? Yes \_\_\_\_\_ No \_\_\_\_\_ **If yes**, please list year completed: \_\_\_\_\_

**PDMP registration:**

Are you registered for the Prescription Drug Monitoring Program (PDMP)

Yes \_\_\_\_\_ No \_\_\_\_\_

For information on PDMP registration

<https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/PDMP/pages/index.aspx>

For information on HHS Cultural Competency Program for Oral Health Professionals

<https://oralhealth.thinkculturalhealth.hhs.gov/default.asp>

For Information and Technical Assistance on the Americans with Disabilities Act, go to ADA.gov

[https://www.ada.gov/2010\\_regs.htm](https://www.ada.gov/2010_regs.htm)

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_