Angel Dental Care

Associate Application Form

GENERAL INFORMATION

First Name_____MI_____Last Name_____

Street Address_____APT # _____

City_____State_____Zip Code_____

Home Phone _____Office Phone_____Mobile_____Pager/Other_____

At which number would you like to be reached? _____

E-mail Address_____ Social Security Number_____-_____-_____

Emergency Contact Information

Name _____Relation_____Number_____

	Yes	No
Are you eligible for employment in the USA?	❑	❑
Are you currently employed?	❑	❑
If so, may we inquire of your present employer?	❑	❑
Have you ever applied for an Angel Dental Care position before?	❑	❑
Where and when? _____		
Have you ever worked for Angel Dental Care?	❑	❑
Where and when? _____		
If "YES", reasons for leaving: _____		

Who referred you to Angel Dental Care?

❑ Directory (Yellow Pages)	❑ Employment Agency	❑ Friend	❑ Relative
❑ Our Website	❑ Other Web Site Advertisement	❑ State Employment Office	❑ Walk-in
❑ Newspaper Advertisement	❑ College Placement Service	❑ MSDA Newsletter Ad	❑ Other _____

If offered the position, when are you available to start: Specific Date:_____/_____/_____ Week(s)____ Month(s)____

Anticipated Salary/Rate:

❑ Hourly Rate $	❑ Salary Rate $	❑ % Production
❑ % of Collection	❑ % of Collection & Production	

EDUCATION BACKGROUND

Dental School

Graduate School Attended:

Name of School	*City*	*State/Country*	*Degree*	*Dates Attended*

Have you participated in any additional training?
(i.e. Specialty Training, Residency, Fellowship)

Name of school/hospital	*State*	*From (MO/YR)*	*To (M/YR)*	*Type Completed*
Name of school/hospital	*State*	*From (MO/YR)*	*To (M/YR)*	*Type Completed*

Undergraduate School Attended:

Name of School	*City*	*State/Country*	*Degree*	*Dates Attended*

Have you participated in any continuing dental education within the last three years? ❑ Yes ❑ No
If "YES", how many credit hours? _____

Name of school/hospital	*State*	*From (MO/YR)*	*To (M/YR)*	*Type Completed*
Name of school/hospital	*State*	*From (MO/YR)*	*To (M/YR)*	*Type Completed*

What are the most Recent CE courses you have attended?

Date:_____Subject:_____Where:_____

Date:_____Subject:_____Where:_____

Are you currently certified in: ❑ CPR ❑ ACLS ❑ ATLS

State in which you hold a license: STATE_____ DENTAL LICENCE # _____ DEA LICENSE _____

To which local or national dental societies do you belong?

❑ ADA ❑ MSDA ❑ AGD ❑ Southern MD Dental Society ❑ Korean American Dental Association

❑ Other

EMPLOYMENT HISTORY

Practice Information Section: Please provide this information for each previous practice you have practiced in. List the actual locations, no P.O. Boxes of mail-only addresses. If you have more than three locations, you may use the extra space at the end of this form or a separate sheet. Please begin with the **most recent**.

Practice Name_____

Street Address_____

City_____State_____Zip Code_____

Telephone_____Fax_____Website_____

Date Position Started_____ Date Position Ended_____

Reasons for Leaving:

Indicate total number in practice:

_____ Dentists_____ Hygienist _____ Assistants _____ Receptionists _____Treatment Rooms _____ Lab Techs

Rate at start of position:

❑ Starting hourly rate $ ❑ Starting salary rate $ ❑ % of Collection & Production

What is your current average monthly production? $_____

What is your current average monthly collection? $_____

What is your current average salary? $_____

Rate at end of position:

❑ Ending hourly rate $ ❑ Ending Salary rate $ ❑ % of Collection & Production

Practice Name_____

Street Address_____

City_____State_____Zip Code_____

Telephone_____Fax_____Website_____

Date Position Started_____ Date Position Ended_____

Reasons for Leaving:

Indicate total number in practice:

_____ Dentists_____ Hygienist _____ Assistants _____ Receptionists _____Treatment Rooms _____ Lab Techs

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What is your current average salary? $_____

Rate at end of position:

❑ Ending hourly rate $ ❑ Ending Salary rate $ ❑ % of Collection & Production

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Practice Name_____

Street Address_____

City_____State_____Zip Code_____

Telephone_____Fax_____Website_____

Date Position Started_____ Date Position Ended_____

Reasons for Leaving:

Indicate total number in practice:

_____ Dentists_____ Hygienist _____ Assistants _____ Receptionists _____Treatment Rooms _____ Lab Techs

Rate at start of position:

❑ Starting hourly rate $ ❑ Starting salary rate $ ❑ % of Collection & Production

What is your current average monthly production? $_____

What is your current average monthly collection? $_____

What is your current average salary? $_____

Rate at end of position:

❑ Ending hourly rate $ ❑ Ending Salary rate $ ❑ % of Collection & Production

If available, in which location would you like to practice?

Annapolis	❑	Columbia/Laurel/Clarksville	❑
Catonsville	❑	Owings Mills	❑
Towson	❑	Glen Burnie	❑
White Marsh	❑	Essex	❑
Rockville	❑	College Park	❑
Pikesville	❑	Silver Spring	❑

Do you see yourself employed in our company as:

Short Term 1-3 years

Intermediate Term 3-6 years

Long Term 7-10 years

What is your 10 year plan?

_____

_____

Please indicate the average weekly numbers, under each of the following categories.

Patients Seen per Week_____ Hours per Week_____ Walk-in/Emergency Patients per Day_____

Patients Seen per Day_____ Patients Seen per Month_____

What is your current work schedule?

Monday From:_____To:_____ Tuesday From:_____To:_____

Wednesday From:_____To:_____ Thursday From:_____To:_____

Friday From:_____To:_____ Saturday From:_____To:_____

Sunday: From:_____To:_____

Questionnaire

- Do you adhere to the Americans with Disabilities Act and treat patients who have HIV/AIDS? ❑ Yes ❑ No
- Do you take precautions against blood borne diseases in your practice (including but not limited to wearing masks and surgical gloves). ❑ Yes ❑ No
- Do you autoclave/sterilize equipment after each patient? ❑ Yes ❑ No
- Do you adhere to the OSHA guidelines? ❑ Yes ❑ No
- Will you utilize infection control and barrier techniques according to OSHA/CDC standards for blood borne pathogens? ❑ Yes ❑ No
- Will you clean, heat, sterilize high-speed, air driven hand pieces and prophy angles between each ❑ Yes ❑ No
- Will you comply with OSHA requirements with respect to hazardous waste materials? ❑ Yes ❑ No
- Will you be on 24-hour call and available at any time for your patients using the company pager, which will be provided by the company? ❑ Yes ❑ No
- Will you use I-V Sedation or general anesthesia in our office? ❑ Yes ❑ No
- Have you had involvement in the design, manufacture, or distribution of any dental product(s)? ❑ Yes ❑ No
- Have you ever designed or written an instruction manual for products for use by other dentists? ❑ Yes ❑ No
- Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA ❑ Yes ❑ No
- Do you treat or review treatment of federal prison inmates? ❑ Yes ❑ No
- Will you comply with all federal, state, and local laws in the conduct of your profession including those prohibiting discrimination against the disabled? ❑ Yes ❑ No

In the following questions, please fully explain any "Yes" answer at the end of this application along with proper documents.

- Have any malpractice claims or suits been filed against you? (If claim or suit was resolved by settlement please forward appropriate information) ❑ Yes ❑ No
- Has any information pertaining to you ever been reported to the National Practitioner Data Bank? (If Yes, include copy of report) ❑ Yes ❑ No
- Have you ever been disciplined by any State Board of Dental Examiners or any Misconduct Board? ❑ Yes ❑ No
- Has your professional license ever been denied, revoked, limited, suspended, put on probation, reprimanded or voluntarily relinquished in any state? ❑ Yes ❑ No
- Has your DEA registration ever been denied, revoked, limited, suspended, or voluntarily relinquished? ❑ Yes ❑ No
- Have you ever had, or been advised, to seek treatment for any chemical dependency or substance abuse condition? ❑ Yes ❑ No
- Have you ever been convicted of a criminal offense? ❑ Yes ❑ No
- Have you ever voluntarily relinquished your participation or been denied, expelled, or suspended from participating in any state or federal program including Medicare or Medicaid? ❑ Yes ❑ No
- Have you ever been refused membership or has your membership ever been revoked, suspended, limited in a health care facility professional staff or in a managed care plan? ❑ Yes ❑ No
- Have you ever been subject to any Peer Review action? ❑ Yes ❑ No
- Have you ever had or do you presently have any mental condition, physical condition (such as infectious disease), or health status that interferes or could interfere with your ability to practice dentistry or in any way endangers or could endanger your patients? ❑ Yes ❑ No

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- Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license revoked, suspended, restricted, subject to a reprimand, placed on probation, or voluntarily surrendered? ❑ Yes ❑ No
- Have you had any professional liability insurances refused, cancelled, or a non-renewal? ❑ Yes ❑ No
- Do you have knowledge of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge or any alleged injury arising out of the rendering or failing to render professional services which may give rise to a claim? ❑ Yes ❑ No

  If "YES", have these been reported to your insurer? ❑ Yes ❑ No
  IF SO PLEASE PROVIDE A COPY OF THE REPORTS

- Have you ever had any instances in the past where the patient(s) had an unexpected adverse result, including but not limited to:
  1. Paresthesia ❑ Yes ❑ No
  2. Hospitalization ❑ Yes ❑ No
  3. Death ❑ Yes ❑ No

  If "YES", to any of these instances, have they been reported to your insurer? ❑ Yes ❑ No
  If so, have they acknowledged receipt of this claim(s)? ❑ Yes ❑ No
  Please provide a copy of their acknowledgement.

- Are you now, or have you ever been involved, directly or indirectly, in a claim or suit arising out of personal injury associated with patient care? ❑ Yes ❑ No

  If "YES", have these been reported to your insurer? ❑ Yes ❑ No
  IS SO, PLEASE PROVIDE A COPY OF THE REPORT.

- Have you incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your dental specialty? (I.e. alcoholism, convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, abuse, addiction to narcotics or other controlled substances, etc.) ❑ Yes ❑ No

  If Yes, state illness or disability, date(s), and identify treating physician in space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the company to complete the reviewing of your application.

Type	**Duration**	**Treating Physician (name & address**

BUSINESS PRACTICES

Do you take medical histories prior to treatment? ❑ Yes ❑ No

How often do you update health histories? Year(s) Month(s) Yes No

For procedures you deem invasive, do you engage in an educational conversation with the patient covering the following topics ❑ ❑

(If yes, please indicate which topics are covered)

- ❑ Diagnosis
- ❑ Recommended Treatment
- ❑ Principal Risks and Complications
- ❑ Expected Benefits of Treatment
- ❑ Possible Outcome if Patient Rejects Treatment
- ❑ Alternatives to Suggested Treatment
- ❑ Necess Principal Risks and Complications
- ❑ No Warranty or Guarantee

	Yes	No
Do you document the discussion in the patient record and/or obtain a written informed consent from patient?	❑	❑
Does this education conversation provide your patients the opportunity to have you answer their questions?	❑	❑

Do you practice as:

- ❑ General Dentist
- ❑ Periodontist
- ❑ Oral & Maxillofacial Surgeon
- ❑ Other
- ❑ Orthodontist
- ❑ Prosthodontist
- ❑ Oral Pathologist
- ❑ Pediatric Dentist
- Endodontist
- ❑ Dental Anesthesiologist

Please check procedures you will perform:

- ❑ Composite Restorations
- ❑ Periodontal Therapy
- ❑ Crown and Bridge
- ❑ Implants

Implant Type:

- ❑ Root Form
- ❑ Abutment
- ❑ TMJ Treatment
- ❑ Subperiostal
- ❑ Submucosal
- ❑ Occlusal Equilibrations
- ❑ Other_____ *Please explain*
- ❑ Prosthesis
- ❑ Splints/Night Guards

- ❑ Forensic Dentistry
- ❑ Third Molar Extractions
  - ___ Erupted
  - ___ Partial Bony
  - ___ Impacted
- ❑ Root Canal
- ❑ Sargenti RCT Method utilizing N2 or Similar Paste

What form of Anesthesia will you use?

- ❑ Local
- ❑ Nitrous Oxide
- ❑ Intravenous/Intramuscular
- ❑ Other
- ❑ Oral (Chloral Hydrate)
- ❑ Inhalation (Except Nitrous Oxide)
- ❑ Acupuncture

- Which branch of dentistry would you be willing to practice? Rank these fields from 1to 10, with 1 being the most:
  - ___ Preventive Cleaning
  - ___ Restoratives
  - ___ Prosthodontics (fixed)
  - ___ Prosthetics (removable)
  - ___ Prosthetics (complete)
  - ___ Oral Surgery
  - ___ Endodontics
  - ___ Implants
  - ___ Pedodontics
- Do you mind doing hygiene for your own in file patients? We do not hire hygienist in our practice. ❑ Yes ❑ No
- Do you mind using only composite fillings for both anterior and posterior teeth? We do use amalgam. ❑ Yes ❑ No

- Are you familiar with Abfractions? What are they? _____ ❑ Yes ❑ No
  _____
- Do you mind having a business card with your picture on it? ❑ Yes ❑ No
- Will you do Root Canal Treatment on:
  a) Anterior ❑ Yes ❑ No
  b) Bicsupid ❑ Yes ❑ No
  c) First Maxillary Molar ❑ Yes ❑ No
  d) First Mandibular Molar ❑ Yes ❑ No
  e) Second Maxillary Molar ❑ Yes ❑ No
  f) Second Mandibular Molar ❑ Yes ❑ No
- Which system do you use for instrument use for RCT?
  Hand Rotary Which kind? _____
- Which system would you use to fill a root canal?
  Vertical Lateral Which brand. _____
- Did you use an Apex Locator? If yes, which brand? _____ ❑ Yes ❑ No
- Are you familiar with the Obtura II System? ❑ Yes ❑ No

If "YES", what do you know of this system? _____
_____

- Will you do a surgical extraction on: *(Place a Y or N in the space provided)*
  ____ Tooth
  ____ Rooth
  ____ Soft Tissue impaction
  ____ Partial Bone impaction
  ____ Full Bone impaction
- What core material do you use for a Post and Core?
  _____
- Have you used any of the following:

  Captek Crowns
  If yes, what is a Captek Crowns? _____ ❑ Yes ❑ No

  Empress I, II Crowns
  If yes, what is a Empras I, II Crown? _____ ❑ Yes ❑ No

  Targis/ Vectris Crowns
  If yes, what is a Targis/ Vectris Crown? _____ ❑ Yes ❑ No
- What do you know of these products? _____
  _____
- Did you do any Implant care? ❑ Yes ❑ No

Surgical Phase Single Implant With which system _____
Multiple Implant With which system _____

Prosthetic Phase

Single Implant With which System _____ **Implant Bridge** With which System _____

Single Anterior implant With which System _____ **Denture with bar supported by implant** With which System _____

Single Posterior implant With which System _____

Denture with attachments supported by implant With which System _____

- Have you used Digital X-rays before? Which Brand? _____ ❑ Yes ❑ No
- Have you done any CE courses in implantology?

Date: _____Where: _____ Sponsoring Company: _____

- Will you work on mentally challenged patients? ❑ Yes ❑ No
- Will you work on physically challenged patients? ❑ Yes ❑ No
- Have you had any experience in dealing with mentally of physically challenged patients? ❑ Yes ❑ No
- Will you do bleaching? ❑ Yes ❑ No
- Do you work on children? ❑ Yes ❑ No
- If "YES at what age would you perform restorative dentistry on children? ❑ 3 yrs ❑ 4 yrs ❑ 5 yrs ❑ 6-12 yrs
- What is Valpast and Flexite?

_____

_____

If you have a patient who has an existing complete denture and he/she requests a new one, how would you accomplish this in **only three visits?**

_____

_____

- What do you know about:

Periochip _____

_____

Atridox _____

_____

The Wand _____

_____

Periostat _____

_____

Dentails _____

_____

Arestin _____

_____

How would you treat sensitivity in teeth after performing Scaling and Root Planning?

_____

- How would you prevent sensitivity after a composite filling? ❑ Yes ❑ No
- Have you used a IntraOral Camera before? ❑ Yes ❑ No
- If yes, what brand? _____
- Have you had any experience with computer software for clinical use? ❑ Yes ❑ No
- If yes, what software? _____
- How much experience with this software do you have? ❑ Beginner ❑ Intermediate ❑ Advanced
- Have you used any self-explanatory or educational software to explain the clinical aspect of treatment plans to a patient? ❑ Yes ❑ No
- Will you talk about the clinical aspect of a treatment plan to the patient? ❑ Yes ❑ No
- Will you talk about the financial aspect of a treatment plan to the patient? ❑ Yes ❑ No

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- Do you have experience with: ❑ HMO ❑ DMO ❑ PPO ❑ Traditional Dental Plans
- What is your opinion on HMO's? _____
- What is your opinion on PPO's? _____
- In your previous or existing job, what is the percentage of patient base in your practice

❑ HMO Ins. % ❑ Traditional Ins. % ❑ Discounted Insurance Plan %

❑ PPO Ins. % ❑ Fee for Service %

REFERENCES

Below, give the names of three persons you are not related to, who you have know for at least one year.

NAME	ADDRESS	PHONE NUMBER	YEARS ACQUAINTED

PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have no knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company.

I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangements with any other dentist, firm, or professional association.

I also understand that the company may wish to contact persons, hospitals, schools, employers, and other entities listed in this application to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contact. Therefore, I hereby instruct any such person, hospital, school, employer, or other entity to release to the company any information regarding me, which the company, in good faith, believes to be applicable and pertinent to this application.

I also understand agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

I agree that I will not at any time, in any fashion, form or manner, either directly or indirectly, divulge, disclose or communicate to any person, firm, or corporation any information of any kind, nature, or description concerning any matters affecting or relating to the dental practice of the Corporation.

I agree that I will not at any time, in any fashion, form or manner, either directly or indirectly, divulge, disclose or communicate to any person, firm, or corporation any information of any kind, nature, or description concerning any matters regarding any offer except to my spouse, if any, tax, and/or other financial advisors and my legal counsel, who will be instructed to follow and will be bound by the confidentiality clause, or as may be required by law, or as agreed to in writing by the parties. Dentist warrants that, prior to the execution of any Agreement, the terms thereof have not been disclosed by me in any manner to any person.

Dentist Name _____ Signature _____

Date Signed: _____
MM/DD/YY