



Provider Information Application

Doctor _____

Office _____

Address _____ City _____ Zip _____

Office Phone # _____ Fax # _____

Email Address _____ Web Site _____

College _____ Date _____ Degree _____

Dental School _____ Date _____ Degree _____

Other Graduate Training _____ Date _____ Degree _____

State(s) Licensed to Practice _____ Date _____

Associate Name _____ Degree _____

Associate Name _____ Degree _____

Associate Name _____ Degree _____

Hygienist Name _____ Degree _____

Office Manager(s) _____

Number of Employees - Full Time _____ Part Time _____

Average # of Patients per Month _____ Maximum Patient Capacity per Month _____

Years at Current Location _____ # of Operatories _____ In-House Lab? _____

Office Hours _____
Monday Tuesday Wednesday Thursday Friday Saturday

Emergency Service Capability _____

Credit Cards Accepted _____

Languages (other than English) _____

Tell Us About Your Office (for Appleton Web Site) _____

Has your license ever been suspended, revoked or other disciplinary action taken? _____

If yes, give reason and dates _____

I verify the above information is accurate and true, and I understand this application is not an Agreement.



Signature of Applicant

Date

State License Number - Please Attach a copy