

GENERAL INFORMATION

Name _____ Policy No. _____
 Effective Or Renewal Date ____/____/____ State _____

PART A: ANESTHESIA

1. Do You Use Or Have:

a. Oral/Maxillofacial Anesthesia Permit?	Yes	No
IF YES: Permit No. _____ State _____ Expiration Date ____/____/____		
b. Continual Blood Pressure Monitoring Either By Use Of:		
i. An Electronic Monitor? Or	Yes	No
ii. A Standard Blood Pressure Cuff With Checks At Appropriate Intervals?	Yes	No
c. Continuous Electrocardiographic Display (EKG)?	Yes	No
d. Precordial, Esophageal Or Pretracheal Stethoscope?	Yes	No
e. Pulse Oximeter?	Yes	No
IF YES: Does It Have An Alarm System?	Yes	No
f. Any Other Devices (Explain) _____		
2. What Type Of Anesthesia Do You Perform?

a. Local Including Nitrous Oxide _____ %	
b. Conscious _____ %	
c. General _____ %	
3. What Type Of General Anesthesia Followup Procedures Do You Use?

4. Are You Advanced Cardiac Life Support (ACLS) Certified? Yes No
5. Are Your Staff Members Basic Cardiac Life Support (BCLS) Certified? Yes No
6. What Type Of Emergency Equipment Do You Have On Hand? (Please Describe):

7. Do You Perform Conscious Sedation, Deep Sedation Or General Anesthesia On Patients Whom You Are **Not** Performing Dental Or Surgical Treatment? Yes No
 IF YES, PLEASE DESCRIBE THE VOLUME AND CIRCUMSTANCES:

Do You Perform Any Of The Following Procedures?		# Of Procedures Per Year	Elective		Non-Elective*	
			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
1. Rhinoplasty	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Blepharoplasty	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Liposuction Above The Neck	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Liposuction Below The Neck	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Hair Transplants	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Blepharopigmentation	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Facelifts/Brow lifts/Forehead lifts	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Botox Injections	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Filler Injections	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Genioplasty	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Wrinkle Remover	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Fat Transplantation	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Scalp Reductions	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14. Tattooing	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15. Tattoo Removal	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. Collagen Injections	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Silicone Injections	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Laser Resurfacing Or Chemical Peels	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. Malar Augmentation	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. Superficial Varicosities By Sclerosing Solution Chemical Peels	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21. Osseointegrated Implant Placement	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. Subperiosteal Or Blade Implant Placement	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23. Microsurgery	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24. Nerve Repair	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25. TMJ Arthroscopy	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
26. TMJ Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
27. Cosmetic Surgery Below The Neck (List Procedures):	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
28. Laser Surgery (List Procedures):	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
29. Do You Perform Experimental Surgery? (Describe):	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

*NON-ELECTIVE PROCEDURES ARE DIRECTLY RELATED TO AND PART OF TREATMENT FOR DENTAL CONDITIONS.

PART C: EDUCATIONAL AND TRAINING INFORMATION

1. Please Include All Pertinent Training. If Preferred, You May Attach Your CV.

NAME OF INSTITUTION	DATES (MM/YY)		SPECIALTY AND/OR DEGREE
	FROM	TO	
Dental School:	___/___	___/___	
Medical School:	___/___	___/___	
Internship:	___/___	___/___	
Residency I:	___/___	___/___	
Residency II:	___/___	___/___	
Fellowship:	___/___	___/___	

2. Are You Board Eligible? Yes No Or Board Certified? Yes No

IF **BOARD CERTIFIED**, DATE OF CERTIFICATION ___/___/___

3. Please Indicate All Of Your Professional Degrees:

DDS DMD MD BS Other _____

4. List Any Specialty Boards, Associations Or Professional Organizations Of Which You Are A Member.

PART D: PATTERN OF PRACTICE

1. Do You Take A Medical History Of The Patient Before The Procedure Is Performed? Yes No

2. Is **Written** Informed Consent Obtained On Each Procedure? Yes No

3. Is **Oral** Informed Consent Obtained On Each Procedure And Documented In The Patient's Record? Yes No

4. Surgery Is Performed In:

- a. The Office _____ %
- b. A Surgicenter _____ %
- c. A Hospital _____ %
- d. Other _____ %
 (Please Specify) 100%

PART D: PATTERN OF PRACTICE CONTINUED

5. Do You Transfer Or Delegate Post-Operative Care To Others Besides Yourself? Yes No
IF YES, PLEASE EXPLAIN:

6. Is Major** Surgery Ever Performed Outside The Hospital? Yes No
IF YES, PLEASE EXPLAIN:

7. Please Name The Hospitals Where You Have Privileges To Perform Oral/Maxillofacial Surgery:

8. Are You On The Active Teaching Facility At A Training Institution? Yes No
IF YES, PLEASE PROVIDE THE NAMES OF THE INSTITUTIONS, THE DATES OF THE FACULTY APPOINTMENT AND A DESCRIPTION OF YOUR DUTIES:

9. Do You Practice Itinerant Surgery? Yes No
IF YES, PLEASE DESCRIBE:

**For Example, Orthognathic Surgery, Surgical Intervention Of Ludwig's Angina Or Pan Facial Abscess, Treatment Of Facial Fractures.

I Understand Information Submitted Herein Becomes Part Of The Professional Protector Plan Professional Liability Insurance Application For Dentists As Submitted.

Signature

Date