CAPITOL DENTAL CARE
PROVIDER INTAKE FORM

Providers Name and Degree: _____

Primary Office Contact: _____

Office Name (if different than provider's name): _____

Physical Address: _____

Mailing Address (if different than physical address): _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____ E-mail: _____

Office Web Address: _____

Type (circle one): General Dentist Pedo Perio Endo Oral Surgeon Denturist EPDH

Organization Type: Sole Proprietorship Partnership LLC PC Other: _____

OFFICE HOURS:

Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____

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 as a condition of payment consideration. Are you requesting to participate in community outreach from this location? Yes____ No ____ If yes, please explain: _____

_____

Will you be providing dental treatment in your office using general anesthetic 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 _____
Do you have patient age limitations? Yes_____ No _____ If yes, please indicate age: _____
Will you see special needs patients? Yes_____ No _____ If yes, please identify any limitations: _____

_____

Please indicate the access aids you have in your location: (check all that apply)

Public Transportation _____ Street level parking _____ Wheelchair ramp _____
Corridor hand railings _____ Elevator _____ Elevator accessible from a wheelchair _____
Wheelchair entry to operatory/lavatory _____ Hand railings in operatory/lavatory _____

Do you or your staff speak a foreign language? Yes____ No ____ If yes, please list: _____

Do you provide and/or have emergency contact and coverage for your patients? Yes____ No ____

Additional Comments: _____

_____

_____

Completed By: _____ Date: _____