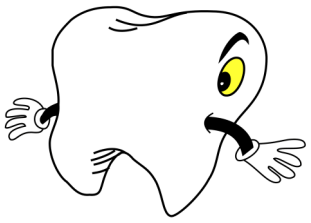
Center Profile



This form is for existing corporate facilities that are adding a new facility.

Please Tell Us About Your Office

What is the name of your practice? _____

What is the physical address of the Office?_____

City:_____ State:_____ Zip Code:_____

What is the office phone number?(_____)_____-_____ Fax Number?(_____)_____-_____

Office manager's name & email:_____

Is your office in a Metropolitan Area (over 100,000 people) [ ] Yes [ ] No (If no) miles from a Metro Area? _____miles

Are languages other than English spoken in your office? [ ] Yes [ ] No (if yes, please specify) _____

Please Tell Us About Your Operatories and Patient Capacity

How many operatories do you have?_____ How many assistants do you have?_____

Do you have a hygiene department? [ ] Yes [ ] No (if yes) How many hygienists do you have?_____

How many additional patients is your office willing to accommodate on a monthly basis? 10-20 21-50 51-70 71-90 91-100 over 100

Please Tell Us What Days and Hours You are Open

Days Open: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

Office Hours: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Please Tell Us About Your Payment Policy

Please check the credit cards that you accept: [ ] Mastercard [ ] Visa [ ] American Express [ ] Discover [ ] Checks

Other forms of payments that you accept:_____

Equipment Sterilization and Infection Control

Do you sterilize your instruments in office? [ ] Yes [ ] No (if yes) Type of Sterilization used: _____

Do you sterilize your handpieces in office? [ ] Yes [ ] No (if yes) Type of Sterilization used: _____

Do you spore test your sterilization unit? [ ] Yes [ ] No (If yes) how often? _____

If no is checked for any of these questions please explain:_____

Personal Sterilization and Infection Control that is Used in this Office

In the Operatory, Do you wear: **Mask** [ ] Yes [ ] No **Gloves** [ ] Yes [ ] No **Eye Protection** [ ] Yes [ ] No [ ] As Needed

Emergency Control Procedures

Is your office equipped with Oxygen [ ] Yes [ ] No Is your office equipped with a Blood Pressure Device [ ] Yes [ ] No

Is your office equipped with a Defibrillator [ ] Yes [ ] No Does your office have at Least 1 C.P.R. Certified Person [ ] Yes [ ] No

Compliance Procedures

Does your office Meet O.S.H.A. Standards [ ] Yes [ ] No Does your office Have a Written Infection Control Policy [ ] Yes [ ] No

Does your office Have a Written Hazard Control Policy [ ] Yes [ ] No Does your office have a written H.I.P.P.A. policy [ ] Yes [ ] No

Is your office able to accommodate patients with Disabilities (Special question for our disabled members) [ ] Yes [ ] No

All information in this profile is becomes the property of Savon Professional Services, Inc., and is made available for member use.

Please mail this completed form to Savon Dental Plan P.O. Box 54277, Phoenix, AZ 85078

Or scan and email it to ProviderServices@SavonDentalPlan.com