



OHIO  
DENTAL INDIVIDUAL  
APPLICATION

\*If previously insured with Medical Protective, please provide the policy number.

Policy # \_\_\_\_\_

Please Fax or E-Mail Application: 800-398-6726 / dental@medpro.com  
If you have questions, please contact your agent or call 1-800-4-MedPro

# DENTAL INDIVIDUAL APPLICATION



## I. GENERAL INFORMATION

Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".

**A.** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_  
Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Social Security Number (Optional) \_\_\_\_\_  
National Provider Identifier (NPI) \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Business Fax \_\_\_\_\_ Business Phone \_\_\_\_\_ Residence/Cell Phone \_\_\_\_\_

### B. Practice Location(s):

(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

#### 1. Primary Location:

% of Practice \_\_\_\_\_ Type of Location:  Hospital  Office  Residence  
Location Name \_\_\_\_\_  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_

#### 2. Additional Location:

% of Practice \_\_\_\_\_ Type of Location:  Hospital  Office  Residence  
Location Name \_\_\_\_\_  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_

### C. Preferred Billing and Correspondence Address:

Location Number (From Section B. above) \_\_\_\_\_  Other (please enter below) \_\_\_\_\_  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## II. EDUCATIONAL BACKGROUND

**A. Are you entering private practice for the first time?**  Yes  No

**B. Have you completed a risk management education course within the last twelve (12) months?**  Yes  No

If you answered yes, did the course provide **all** of the following?  Yes  No

1. A minimum of three continuing dental education (CDE) hours;
2. Sponsored by an approved national/regional dental education sponsor; and
3. Strictly adheres to a risk management (loss prevention) curriculum

### C. Dental School:

Name of School \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Degree \_\_\_\_\_ Completed From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

## II. EDUCATIONAL BACKGROUND (CONTINUED)

**D. Residency:**

(Please list all resident training locations - i.e. Residency Specialty Training, Anesthesia Residency Training, etc.)  
 (If you were involved in more than one specialty training program, please enter each program separately.)

1. Name of Hospital/Facility/Program \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty Type \_\_\_\_\_  
 Completed?  Yes  No  Still in Training      From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_
  
2. Name of Hospital/Facility/Program \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty Type \_\_\_\_\_  
 Completed?  Yes  No  Still in Training      From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

## III. PRACTICE INFORMATION

**A. States in which you hold a license to practice dentistry:**

Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

- |  | Active                   | Inactive                 | Temporary                | Pending                  |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. State _____ License # _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. State _____ License # _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DEA License? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                          |                          |                          |

**B. Please indicate your earliest start date at your current location(s):** (MM/YYYY) \_\_\_\_\_

**C. Do you have previous practice locations?**  Yes  No

If yes, list most recent location first dating back within the past ten years.

1. Name of Practice \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty \_\_\_\_\_ From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_
  
2. Name of Practice \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty \_\_\_\_\_ From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

**D. In the past ten years, please explain any gaps greater than one year between practice locations.** \_\_\_\_\_  
 \_\_\_\_\_

**E. To which dental societies or associations do you belong?** \_\_\_\_\_  
 \_\_\_\_\_

**F. Please indicate the estimated average weekly numbers, under each of the following categories, for which you require Medical Protective coverage:** (If none, please enter '0' in the space provided.)

# Patients Per Week \_\_\_\_\_ Hours Per Week \_\_\_\_\_ Unscheduled New Walk-In Patients Per Week \_\_\_\_\_

## IV. RATING INFORMATION

**A. Please check your present specialty:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General Dentist   | <input type="checkbox"/> Prosthodontist                         | <input type="checkbox"/> Oral & Maxillofacial Surgeon |
| <input type="checkbox"/> Orthodontist      | <input type="checkbox"/> Oral Pathologist                       | <input type="checkbox"/> Dual Degree                  |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Dental Anesthesiologist                | <input type="checkbox"/> Board Certified              |
| <input type="checkbox"/> Endodontist       | <input type="checkbox"/> Pain Management (Please explain) _____ | Date of Certification (MM/YYYY) _____                 |
| <input type="checkbox"/> Periodontist      | <input type="checkbox"/> Other (Please explain) _____           |   |

**B. Please check procedures you will perform in your practice:**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Orthodontic Full Mouth Banding</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Placement of Mini Implants for Orthodontic/Prosthesis</b><br><input type="checkbox"/> <b>Implant Prosthesis/Supported Prosthesis</b><br><input type="checkbox"/> <b>Sargenti Root Canal Method Utilizing N2 or Similar Paste</b><br><input type="checkbox"/> <b>Surgical Placement of Implant Fixtures</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Botox, Dermal Fillers (i.e. Injections)</b><br><input type="checkbox"/> <b>Cosmetic Full Mouth Rehabilitation</b><br><input type="checkbox"/> <b>Alternative (Holistic) Dentistry/Medicine</b><br>Please explain _____<br><input type="checkbox"/> <b>Sleep Apnea Therapy</b><br>Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> <b>Obesity/Weight Control Treatment</b><br><br><u>Third Molar Extractions (CPT/CDT Codes)</u><br><input type="checkbox"/> <b>Erupted (D7110, D7120, D7210)</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Partially Impacted (D7220, D7230)</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Fully Impacted (D7240, D7241, D7250)</b><br>Year you began this procedure (YYYY) _____ | <input type="checkbox"/> <b>Sinus Lifts</b><br><input type="checkbox"/> <b>Palatal Inserts</b><br>Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> <b>Nerve Grafts</b><br><input type="checkbox"/> <b>Cleft Lip and Palate Surgery</b><br><input type="checkbox"/> <b>Face Lifts</b><br><input type="checkbox"/> <b>Management of Malignant Lesions</b><br><input type="checkbox"/> <b>Orthognathic Surgery</b><br><input type="checkbox"/> <b>Rhinoplasty</b><br><input type="checkbox"/> <b>Skin Peels</b><br><input type="checkbox"/> <b>Spa Services</b><br>Please explain _____<br><input type="checkbox"/> <b>TMJ Services</b><br><input type="checkbox"/> <b>Arthroscopy</b><br><input type="checkbox"/> <b>Implant</b><br><input type="checkbox"/> <b>Reconstruction</b><br><input type="checkbox"/> <b>Trigger Point Injections</b><br><input type="checkbox"/> <b>Other</b><br>Please explain _____ |
|---|---|

**C. Indicate the percentage of your practice devoted to the following procedures:**

(Total does not have to equal 100%)

- \_\_\_\_\_ % Denture Procedures       Same Day or Economy       Replacement       Relines
- \_\_\_\_\_ % Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)
- \_\_\_\_\_ % Elective Facial Cosmetic Surgical Procedures (including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)
- \_\_\_\_\_ % Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)
- \_\_\_\_\_ % Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

**D. Please indicate which procedures you perform and whether you obtain informed consent and have received training for each of the procedures selected.**

	<b>Informed Consent Type</b>	<b>Training</b>
<input type="checkbox"/> Orthodontic Full Mouth Banding	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Surgical Placement of Implant Fixtures	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Partially Impacted Third Molar Extractions	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Fully Impacted Third Molar Extractions	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Nitrous Oxide Analgesia	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Conscious Sedation	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> General Anesthesia/Unconscious Sedation	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Facial Surgery	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Botox, Dermal Fillers (i.e. Injections)	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Other (Please explain) _____	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None

**E. Have you discontinued any procedures listed in B. or C. above?**

Yes     No

Which procedures? \_\_\_\_\_ When? (MM/DD/YYYY) \_\_\_\_\_

## V. ANESTHESIA INFORMATION

A. As defined below, please "X" if you, an employee or independent contractor treat patients under:

- Conscious Sedation Utilizing CPT/CDT Code D09241 and D09242 - (excluding nitrous oxide) a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

IM/IV       Oral

- General Anesthesia Utilizing CPT/CDT Code D09220- (to include deep sedation) a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

**If Conscious Sedation or General Anesthesia were checked, please complete the Anesthesia Supplement.**

B.  Please "X" here if this section **does not** apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar nonscheduled drug) or nitrous oxide only.

## VI. ADDITIONAL PROFESSIONAL INFORMATION

A. Do you treat non-federal prison inmates?

Yes  No

If yes, what percentage of your practice is devoted to treating non-federal inmates? \_\_\_\_\_ %

B. Do you treat or review treatment of federal prison inmates?

Yes  No

If yes, please explain \_\_\_\_\_

(If you are covered by other insurance for the activities in A or B of this section, please complete Section VI, Question J.)

C. 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, dental license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?

Yes  No

If yes, please explain and indicate the date(s): Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

D. Has any professional liability insurance company ever declined, refused, cancelled, or non-renewed your coverage, or have you ever had an involuntary deductible or surcharge assessed against your policy?

Yes  No

If yes, please explain and indicate the date(s): Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

E. Have you ever been accused of sexual misconduct of any kind?

Yes  No

If yes, please explain and indicate the date(s): Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

F. Have you ever incurred or become aware of having a condition that impairs your ability to practice your dental specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics, or other controlled substances, etc.)

Yes  No

If yes, state condition, date(s) and identify your treating physician in the 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 underwriting of your application.

Type(s) of Illness \_\_\_\_\_

Date(s) of Treatment(s): From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

Treating Physician(s): Name(s) \_\_\_\_\_ Address(es) \_\_\_\_\_

G. Do you use a collection agency which has the authority to file collection suits without your knowledge?

Yes  No

H. Is the standard of care altered based on the patient's, custodial parent's or legal guardian's ability to pay?

Yes  No

I. Are you affiliated with a group that has more than three active locations?

Yes  No

J. Will you be performing activities which will be covered by another professional liability policy?

Yes  No

If yes, are you an:  Employee  Independent Contractor  Resident/Fellow  Faculty

Practice Name \_\_\_\_\_

Location \_\_\_\_\_

Name of Insurer \_\_\_\_\_

K. Are you affiliated with a management service organization or dental practice franchise?

Yes  No

## VII. PRACTICE ORGANIZATION INFORMATION

Please check boxes that best describe your practice affiliation(s).

**A. Employment Status:**

Employee  
  Shareholder/Partner  
  Independent Contractor  
  Other  
 Date Joined/formed (MM/DD/YYYY) \_\_\_\_\_

**B. Entity / Organization Type:** (You must check at least one box.)

<input type="checkbox"/> Solo Unincorporated/Sole Proprietor <input type="checkbox"/> Solo Incorporated <input type="checkbox"/> Multi-Shareholder Corporation, Partnership, Limited Liability Company <input type="checkbox"/> Licensed Dental Surgery Center <input type="checkbox"/> Clinic Receives Governmental Immunity <input type="checkbox"/> Other (Please explain) _____	<input type="checkbox"/> Mobile Dental Practice <input type="checkbox"/> Nursing Home Based Practice <input type="checkbox"/> Dental School - Faculty <input type="checkbox"/> Clinical supervision of students Hours per week _____ <input type="checkbox"/> Dental Students/Residents
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**C. Name all of your affiliated professional corporations or associations (including DBA's and Individual Dentists):**

\_\_\_\_\_

**D. Is this entity or employer currently insured with The Medical Protective Company?**  Yes  No

If yes, please provide The Medical Protective Company individual, corporation or partnership policy and group number, if known.

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**E. Do you desire coverage for this entity?**  Yes  No

If yes, please select the type of entity coverage desired:

- Shared Limit** - Your individual policy limits will be shared with your **Solo Corporation**. This option is **only** available if you are Solo Incorporated and you have no employed or contracted Dentists.
- Separate Limit** - Available for all Entity/Organization Types. A separate entity application is required.

*To request separate entity coverage, please contact your agent or Med Pro customer service (800-4MedPro) to complete an entity application for consideration.*

## VIII. LOSS INFORMATION

Please complete the Loss Information Supplement for each written request, incident, claim or suit.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints etc...)

For questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

**A. Are you now, or have you ever been involved in a claim or suit arising out of the rendering or failure to render professional services?**  Yes  No

If **yes**, how many? \_\_\_\_\_

**B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you?** This includes but is not limited to the following:  Yes  No

-Cancer                      -Death                      -Permanent Neurological Injury                      -Permanent Nerve Injury

If **yes**, how many? \_\_\_\_\_

**C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?**  Yes  No

If **yes**, how many? \_\_\_\_\_

## IX. COVERAGE INFORMATION

### A. Coverage Desired:

- Occurrence  
 Claims-Made coverage without Prior Acts coverage  
 Claims-Made coverage with Prior Acts coverage  
 Convertible Claims-Made coverage with Prior Acts coverage

### B. Requested Coverage Effective Date:

From (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m. To (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m.

Annual policy term will begin and end on the same month and day.

### C. The Retroactive Date shown on your current Claims-Made policy (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m.

(This date is not required for Occurrence or Claims-Made without Prior Acts policies)

### D. List all previous professional liability insurers in the last ten years:

1. Current Insurer \_\_\_\_\_ Current Premium \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_
2. Previous Insurer: \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_
3. Previous Insurer: \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_

### E. Please explain any gaps in coverage in the past ten years. \_\_\_\_\_

### F. If 'Occurrence' or 'Claims-Made coverage without Prior Acts coverage' was selected as the Coverage Desired and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- An extended reporting endorsement (tail coverage) has been purchased.  
 An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy, for which I am applying for with The Medical Protective Company, if offered, will not provide prior acts coverage.

Initial Here

**Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".**

### G. Limits Desired: \_\_\_\_\_ Per Occurrence/Per Claim Made \_\_\_\_\_ Annual Aggregate

## X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

Yes  No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's home office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name \_\_\_\_\_

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

**Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.**

