# APPLICATION

ALL INFORMATION STRICTLY CONFIDENTIAL
PLEASE PRINT OR TYPE

Name:____________________________________________________
Practice Name:_____________________________________________
Office Address:_____________________________________________
_________________________________________________________
(City) (State) (ZIP)
County:___________________________________________________
Telephone: (Office)______________________ (Fax)_________________
(Other, specify)___________________________________
Office Hours: Mon________Tues________Wed__________Thurs_________Fri________
Sat__________Sun________
Board certified or qualified in any specialty? Yes_______ No_______
If yes, please specify:
_________________________________________________________________________
Practice Limited to specialty of: _______________________________________
Dental School:____________________________________________________
Year of Graduation:_________________________
License Number:___________________________
Office Manager:____________________________
Hygienist: Yes_________ No_____________
Number of auxiliaries:_________
Other Dentists: Yes_________ No_____________
(1) Name:___________________________________________
Dental School:_________________________________________
Year of Graduation:_____________________________________
(2) Name:___________________________________________
Dental School:_________________________________________
Year of Graduation:_____________________________________
Do you have another office? Yes_________ No__________
Address:_______________________________________________________
Telephone Number:_______________________ Emergency Number:_____________________
Would you like to enroll this office also? Yes________ No________
Office Hours: Mon________Tues________Wed__________Thurs_________Fri________
Sat__________Sun________

**FOR OFFICE USE ONLY:**
**ID CODE#:________________________**
**CONTRACT SENT:_________________**
**WAIT LIST:_______________________**
**ACTIVE:__________________________**
**DATE:____________________________**
**APPROVED:_______________________**

**IMPORTANT: YOU MUST ATTACH A COPY OF YOUR DENTAL LICENSE, DEA, CDS, AND THE SCHEDULE PAGE INDICATING MALPRACTICE INSURANCE COVERAGE.**

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**Section I - Equipment**

Please circle the equipment that you currently have in your office:

Cavitron Peripro Autoclave Nitrous Oxide

Answering Machine Answering Service Audio Phones U.V. Light System
Lead Collar Electrosurge Auto Developer Lead Apron

Stage age and condition of your equipment:
Age:__________years old) average Condition: Excellent____Good_____Fair_____Poor____
Comments:____________________________________________________________

## Section II - Specialties and Referrals

Do you have the following? (for G.P.'s)
**Periodontics** Full Case______ Partial Case_________
Comments_______________________________________________________
**Endodontics** Single______ Double______ Triple+___________
Comments_______________________________________________________
**Oral Surgery** Simple Impactions____Complex Impactions______Apicoectomies________
Comments_______________________________________________________
Please list specialists to whom you refer in the following areas:
Periodontist Name________________________Phone_______________________
Endodontist Name________________________Phone_______________________
Oral Surgeon Name________________________Phone_______________________
Covering Dentist Name________________________Phone_______________________
(vacations and emergencies)
Please circle any special degrees, or experience in the following areas:

Special Patient Care TMJ Implantology Nutrition
Pain Management Prosthodontics General Anesthesia
Hollistic Dentistry

## Section III - Miscellaneous

Do you provide gold inlay and onlay service? Yes_____No_____
Do you provide bonding from simple to complex? Yes_____No_____
Do you provide laminate veneers? Yes_____No_____
Do you provide any orthodontic services? Yes_____No_____
Do you provide services for children? Yes_____No_____
Do you accept credit card payments? Yes_____No_____
(If yes, explain)______________________________________________________
Do you plan to remodel your office? Yes_____No_____
Have you recently remodeled your office? Yes_____No_____
Are you affiliated with any hospital or institution? Yes_____No_____
(If yes, explain)______________________________________________________
Are you taking any special courses now, or have you taken any special dentistry courses? Yes_____No_____
(If yes, explain)______________________________________________________
Do you speak any other language besides English? Yes_____No_____
(If yes, explain)______________________________________________________

Print Name_____________________________________ Signature____________________________

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THIS AGREEMENT is made and entered into this _______ day of _______, 20____.

By and between _________________________(hereinafter referred to as the "DENTIST"), who is duly qualified and

Licensed to practice Dentistry is this state with professional offices
At______________________________________________________________________
And MAINLINE DENTAL PLAN, INC. A New Jersey Corporation incorporated under the laws of the State of New Jersey and duly authorized to do business in the state wherein dentist maintains his/her office(s) (hereinafter to as the "PLAN")

**WITNESSETH:**

WHEREAS, PLAN has organized a dental treatment program for both individuals and groups to provide access to a quality dental program for the benefit of members (the term MEMBER as hereinafter used in this AGREEMENT shall be deemed to include any eligible dependents); and

WHEREAS, each MEMBER has entered into an AGREEMENT with the PLAN to receive the benefits conferred by Membership to the PLAN.

NOW, THEREFORE, it is agreed as follows:

1. That the DENTIST agrees to require that all employees of DENTIST and all partners, associates, supervisors, and personnel under his control, render services to MEMBERS in accordance with this AGREEMENT.

2. That the DENTIST agrees to perform all necessary dental services which he customarily renders, to each MEMBER during his regular office hours, subject to a prior appointment; provided, however, that DENTIST shall have the right within the framework of professional ethics to reject any patient seeking his services. If DENTIST should be absent from his practice for any reason for longer than ninety (90) days, the PLAN may terminate this AGREEMENT upon ten (10) days notice by certified or registered mail.

3. That the DENTIST agrees to perform his obligations under this AGREEMENT in accordance with high standards of competence, care and concern for the welfare and needs of MEMBERS, who seek his professional services and in accordance with the "principles of ethics of the American Dental Association." DENTIST further agrees not to differentiate or discriminate in the treatment of MEMBER patients by reason of the fact that they are MEMBERS.

4. That the DENTIST shall maintain the Dentist-Patient relationship with MEMBERS who seek his professional services, and shall be responsible to the patient for quality dental advice and treatment. The parties hereto agree that the DENTIST is an independent contractor and that the PLAN shall not have any control over DENTIST'S practice, his personnel, or his facilities.

5. The PLAN shall be responsible for determining a person's eligibility prior to their becoming a MEMBER.

6. That the DENTIST shall perform all services as required pursuant to the AGREEMENT and DENTIST agrees that all payments for all said services rendered by DENTIST to any MEMBER are required to be paid directly by the MEMBER. The DENTIST agrees to look solely to the MEMBER for payment and to bill at rates not to exceed those set forth in the schedule attached hereto. If any service provided to MEMBER by the DENTIST is not listed in said schedule, DENTIST hereby agrees to bill for said service at a rate not in excess of his usual and customary fee. No fee shall be due from DENTIST to PLAN with respect to the services required pursuant to this AGREEMENT.

7. That the DENTIST will charge for his services at rates not to exceed those set forth in the attached schedule.

8. That the DENTIST hereby agrees that in the event of any unresolved dispute for payment claimed by DENTIST, under no circumstances will DENTIST make or have any claim against the PLAN.

9. That the attached fee schedule may be revised annually by the PLAN to reflect increased costs of dental care. Such revision will be in the PLAN'S sole discretion. The PLAN agrees to notify the DENTIST in writing of the nature and extent of such revision.

10. That this AGREEMENT is not exclusive in any respect, and the PLAN and the MEMBERS are entitled to enter into similar contracts with other dentists and DENTIST is free to enter into similar contracts with other parties, or with other groups not represented by the PLAN, and to maintain his private practice.

11. That DENTIST agrees to notify MAINLINE DENTAL PLAN, INC. in the event that he/she receives notice of any type of claim or litigation within thirty (30) days of receipt of such action brought by a PLAN MEMBER.

12. That DENTIST agrees to carry Malpractice Insurance coverage for his/her practice in an amount not less than $1,000,000 per incident. DENTIST further agrees to provide the PLAN with a "Certificate of Insurance" which provides for ten (10) days notice of cancellation to the PLAN and agrees to indemnify and hold harmless PLAN or any of its agents from all liabilities, costs, and expenses that may be incurred by the PLAN or its agents in connection with any controversy proceeding or litigation arising from the execution of the AGREEMENT with DENTIST or arising from DENTIST'S performance of this AGREEMENT.

13. That the PLAN shall appoint a Dental Director who will be responsible for assuring the standards of dentists who provide dental care to MEMBERS, and who will be a liaison between the PLAN and the DENTIST.

14. That this AGREEMENT shall continue in effect until terminated by wither party upon sixty (60) days notice by

registered or certified mail, except in cases of termination upon ten (10) days notice under Paragraph 2. Notices shall be mailed to DENTIST at the address set forth herein and to PLAN at such address as shall be designated by PLAN from time to time.

15. That in the event this AGREEMENT is terminated by either party in accordance with the procedure set forth herein. DENTIST agrees that at the time the patient seeks an appointment, he will notify each patient who is a MEMBER prior to giving service that the DENTIST is no longer affiliated with the PLAN.

16. That this AGREEMENT is intended to secure the personal services of DENTIST and shall not be assigned or transferred by DENTIST without the written consent of the PLAN.

17. That a waiver of any breach of this AGREEMENT or of any of the terms or conditions by either party shall not be deemed a waiver of any repetition of such breach or in any way affect any other terms or conditions. No waiver shall be valid or binding unless it shall be in writing and signed by the parties.

18. All written notices shall be deemed to have been made at the time of posting, and shall be sent to the following addresses as set forth below.

19. That this AGREEMENT embodies the entire understanding of the parties and may be amended only in writing.

20. That if any one or more of the provisions of this AGREEMENT should be found to be invalid, illegal, or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired. This AGREEMENT shall be governed by the laws of the State of New Jersey.

IN WITNESS WHERE OF, the parties hereto have affixed their signatures this _______ day of
______________________ 20____at ______________________________, New Jersey.

MAINLINE DENTAL PLAN, INC.
By: _________________________
Ryan C. Maher, President

DENTIST
By: ______________________________________________ Print Name: ______________________________
Signature
Address: __________________________________________________________
City/State/Zip Code: ________________________________________________
Telephone: ________________________________________________________

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**Please mail completed application form to:**
**Mainline Dental Plan, Inc.**
**9 Furler Street**
**Totowa, NJ 07512**

**Phone: 1- 877- 880- PLAN (7526) Fax: (702) 880-7531**