

**Oral And  
Maxillofacial  
Surgery**  
Supplemental  
Questionnaire



## INTRODUCTION

Your Full Name:

Policy Number:

**Directions:** Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Please ensure that you sign and date the questionnaire on page 3.**

## SECTION I

### DENTAL LICENSES

1. Please complete the following regarding all states where you are presently or have been previously licensed to practice dentistry in any capacity:

State	License Number	Type	Current Status	If Inactive, Reason for Inactive Status
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="text"/>

2. Has your license to practice dentistry in any jurisdiction **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, fined, subject to probationary terms or conditions or otherwise investigated or limited in any way?  Yes  No

If **yes**, please provide a detailed written narrative (including, but not limited to, date of occurrence, reason for occurrence and resolution) in the Remarks section and include any pertinent documentation (e.g., dental board documents, etc.).

## SECTION II

### ASSOCIATIONS AND PROCEDURES

1. Do you maintain a professional relationship with any dentist?  Yes  No

If **yes**, please complete the following for each dentist and provide proof of his or her professional liability insurance:

Name	Type of Relationship	
<input type="text"/>	<input type="checkbox"/> Employer <input type="checkbox"/> Employee	<input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (specify): <input type="text"/>
<input type="text"/>	<input type="checkbox"/> Employer <input type="checkbox"/> Employee	<input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (specify): <input type="text"/>
<input type="text"/>	<input type="checkbox"/> Employer <input type="checkbox"/> Employee	<input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (specify): <input type="text"/>
<input type="text"/>	<input type="checkbox"/> Employer <input type="checkbox"/> Employee	<input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (specify): <input type="text"/>
<input type="text"/>	<input type="checkbox"/> Employer <input type="checkbox"/> Employee	<input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other (specify): <input type="text"/>

2. Do you perform general dentistry procedures other than those that are incidental to your oral and maxillofacial practice?  Yes  No

If **yes**, please identify the procedure(s) and the percentage of your practice devoted to the performance of general dentistry procedures:

**NOTE:** Please ensure that any dental office in which you perform any procedure/surgery or provide anesthesia for any procedure/surgery in which the patient has been administered spinal epidural anesthesia, moderate (conscious) sedation, deep sedation or general anesthesia was included when you answered the office-based surgery suite question on the Physicians and Surgeons Application (question 5 on page 14) or Current Practice Questionnaire (question 5 on page 11). Please provide proof of each location's accreditation by the AAAASF, AAAHC or similar type of organization.

**For Alaska Oral and Maxillofacial Surgeons Only**

1. Do you administer general anesthesia, or perform procedures on patients who have been administered general anesthesia, in a dental office?  Yes  No

**For California Oral and Maxillofacial Surgeons Only**

2. Do you do any one of the following:

- a. Administer or order the administering of general anesthesia on an outpatient basis?  Yes  No
- b. Administer or order the administering of conscious sedation on an outpatient basis?  Yes  No
- c. Administer or order the administering of oral conscious sedation on an outpatient basis to a patient who is under the age of 13?  Yes  No

**For Rhode Island Oral and Maxillofacial Surgeons Only**

3. Do you administer or permit the administering of any one of the following in a dental office:

- a. General anesthesia/deep sedation?  Yes  No
- b. Inhalation conscious sedation?  Yes  No
- c. Combined conscious sedation?  Yes  No
- d. Parenteral conscious sedation?  Yes  No
- e. Nitrous oxide analgesia?  Yes  No

**If yes,** please provide a copy of the permit issued to you by the Rhode Island Board of Examiners in Dentistry for each type of anesthesia for which you answered yes, and a copy of each dental office's facility permit to allow the administering of the applicable anesthesia services.

**SECTION IV**

**REMARKS**

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

**REPRESENTATIONS AND WARRANTIES**

**NOTE: "Warrant" in the following statement is not applicable to Alaska or Arizona health care providers. By statute, Alaska or Arizona health care providers are only required to represent the truth of their statements and information.**

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

Signature

Date

*(mm/dd/yyyy)*

Name (Print)