HEALTH PARTNERS DENTAL ACCESS, INC.

1 x1
RECENT
PHOTOGRAPH

Please complete all details on the spaces provided on this Clinic Information sheet.

CLINIC INFORMATION SHEET

CLINIC NAME:			
REGISTERED NAME (PER DTI & BIR 2303)			
CLINIC OWNER:			
	(LAST NAME)	**(GIVEN NAME)**	**(M.I.)**
SPECIALIZATION:			
PRC LICENSE NO.:			
TAXPAYER'S IDENTIFICATION NUMBER:		TAX TYPE: ( ) VAT	( ) NON-VAT
SEC REGISTRATION NUMBER(FOR CORPORATION/ PARTNERSHIP):			
HMO ACCREDITATIONS:			
CLINIC ADDRESS: **Kindly provide complete details for mail/postal services (unit or Room no. / Street name / baranggay / province / city)**			
PHONE NUMBER/S:		MOBILE NUMBER:	
		EMAIL ADDRESS:	
CLINIC SCHEDULE:			
NUMBER OF CHAIRS:			

ASSOCIATE DENTIST/S:

(LAST NAME)	(GIVEN NAME)	(M.I.)	PRC LIC #	SPECIALIZATION

CLINIC SECRETARY/ DENTAL ASSISTANT

PLEASE DEPOSIT PAYMENT FOR DENTAL SERVICES TO BELOW ACCOUNT DETAILS
(complete and correct details are necessary for Bank payments/ deposits)

BANK ACCOUNT NAME:	
BANK ACCOUNT NUMBER:	
NAME OF BANK:	BRANCH:
ACCOUNT TYPE: ( ) SAVINGS	( ) CURRENT

DENTIST SIGNATURE OVER PRINTED NAME

PLEASE ATTACH LOCATION MAP OF CLINIC AND PLEASE FILL UP 1 FORM PER BRANCH.