HEALTH PARTNERS DENTAL ACCESS, INC.

1 x1
RECENT
PHOTOGRAPH

Dear Doctor:

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

CLINIC INFORMATION SHEET

CLINIC NAME (DTI REGISTERED NAME/ BIR TRADE NAME):				
CLINIC OWNER:				
	(LAST NAME)		**(GIVEN NAME)**	**(M.I.)**
SPECIALIZATION:				
PRC LICENSE NO.:		TIN NO.:		
TAX TYPE:	( ) NON-VAT	( ) VAT		
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:	( ) by appointment	( ) first come first serve		
ASSOCIATE DENTIST/S:				
(LAST NAME)	(GIVEN NAME)	(M.I.)	PRC LIC #	SPECIALIZATION
CLINIC SECRETARY/ DENTAL ASSISTANT				
ACCOUNT DETAILS (complete and correct details are necessary for Bank payments/ deposits)				
BANK ACCOUNT NAME:				
BANK ACCOUNT NUMBER:				
BANK NAME:		BRANCH:		
( ) SAVINGS		( ) CURRENT		
DENTIST SIGNATURE OVER PRINTED NAME				

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