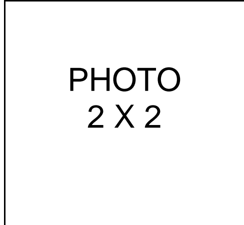

HEALTH PARTNERS-DENTAL ACCESS INC.

hpdac@healthpartnersdental.com; www.healthpartnersdental.com

DENTIST INFORMATION SHEET

NAME:____
(FAMILY) (FIRST) (MI)

ADDRESS:
RESIDENCE____

CLINIC:____

BIRTHDAY:_____________________________

PHONE MOBILE and LANDLINE
Home___________________
Clinic___________________
email : _________________

EDUCATION:

DENTAL SCHOOL:__________________________________
YEAR GRADUATED:______________

SPECIALIZATION/TRAININGS:

FIELD	DATE
________________________________	_______________________
________________________________	_______________________

SPECIALTY BOARD CERTIFICATION:

____

CLINIC SCHEDULE:

____

LICENSE NO:_______________ UPDATED AS OF:_______________

_________________________________,D.M.D.
(Signature Over Printed Name)