

ONLINE QUOTE FORM FOR DENTAL/ORAL SURGEONS PROFESSIONAL LIABILITY INSURANCE

Please answer the questions below by providing as much detail as possible. All information gathered on this form will remain confidential. Before you can submit a Request for Quote, please review our [Privacy Policy](#) and [HIPAA](#) form, then check this box after you have read, accept and understand them.

Submitted by: *

Agency: *

Mailing Address: *

City: *

State: *

Zipcode: *

Phone Number / Area Code: *

Fax: *

Email Address: *

Applicant's Instructions:

1. Complete the online form including the claim form if applicable
2. If you have a CV.(resume) please email to pbs@pbsinsurance or fax to 502-254-1056
3. Please DO NOT complete the application earlier than 60 days before the proposed effective date of coverage.

General Information:

1. (a) Full Name:
Professional Degree:

(b) Principal practice address: County:
City: State: Zip:

(c) Phone: Fax:
E-Mail address: Website address:

(d) Date of Birth (MM/DD/YYYY): / / Place of Birth:

(e) Social Security No: - - Federal Tax ID Number:

2. Are you a U.S. citizen? Yes No
If No, what is your status in the U.S. and current citizenship?

3. (a) Type of practice:

<input type="checkbox"/> solo practitioner (unincorporated)	<input type="checkbox"/> solo practitioner (incorporated)*
<input type="checkbox"/> professional corporation*	<input type="checkbox"/> professional association*
<input type="checkbox"/> limited liability company*	<input type="checkbox"/> partnership*
<input type="checkbox"/> employee of <input type="text"/>	<input type="checkbox"/> independent contractor of <input type="text"/>
<input type="checkbox"/> other <input type="text"/>	

*Specify name of entity:

(b) Do you want coverage for the entity named item 3(a) above? Yes No

(c) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all others practicing under the entity name it item 3(a) above.

4. Do you practice with any dentist not named in item 3(c) above? Yes No
If Yes, provide the name of each dentist and the practice relationship.

5. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Federal DEA License No. and status:

7. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

Name	City	State	Percentage of Work	Type of Privileges
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

8. Do you or the entity firm named in item 3(a) above own (either wholly or in part), operate or administer any hospital, nursing home, surgi-center, urgent care center other facility where medical services are customarily provided? Yes No

If Yes, provide a detailed explanation specifically including the name, location, size, and number of beds.

Education and Training:

1. (a) Provide your dental specialty:

(b) Do you limit your practice to the specialty stated in item (a) above? Yes No

If No, provide details.

2. Are you American dental board certified in any specialty? Yes No

If Yes, provide the following: Board(s) in which you are certified:

Date of certification (MM/DD/YYYY): / / Any recertification date(s): / /

If No, do you plan on taking a Board examination? Yes No

3. Provide the following information:

	Name of Institution	City	State	Date Completed
Dental School	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Internship	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Specialty	<input type="text"/>			
Residency	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Specialty	<input type="text"/>			
Fellowship	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Specialty	<input type="text"/>			
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Specialty	<input type="text"/>			

4. If you graduated from a foreign dental school, provide the date began your practice in the United States: / /

5. Provide a detailed summary of where you have practiced your profession since completing your training:

Street Address	City	State	Country	From (MM/YYYY)	To (MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/>

6. Indicate the professional organizations which you are a member of:

American Association of OMS (AAOMS) American Society of Dentist Anesthesiologists (ASDA)

American College of OMS (ACOMS)

State Society of OMS

American Dental Association

OMS Society - Other

Other (describe)

Scope of Practice

1. Provide the approximate percentage of your practice in the following:

Bone Grafting	<input type="text"/>	%	Implants	<input type="text"/>	%
Cosmetic Dentistry			Restoration	<input type="text"/>	%
Bonding	<input type="text"/>	%	Placement	<input type="text"/>	%
Enamel Shaping	<input type="text"/>	%	Microsurgical Procedures	<input type="text"/>	%
Full Mouth Restoration - Cosmetic Only	<input type="text"/>	%	Oral Pathology	<input type="text"/>	%
Veneers	<input type="text"/>	%	Oral Radiology	<input type="text"/>	%
Whitening with Lasers	<input type="text"/>	%	Orthodontics	<input type="text"/>	%
Other Cosmetic Procedures (describe)	<input type="text"/>	%	Orthognathic Procedures	<input type="text"/>	%
<input type="text"/>			Pediatric Dentistry	<input type="text"/>	%
Non-Dental Cosmetic Procedures (including injecting Botox, collagen and fillers) (describe)	<input type="text"/>	%	Periodontics	<input type="text"/>	%
<input type="text"/>			Prosthodontics	<input type="text"/>	%
			Prosthetics		
			Fixed	<input type="text"/>	%
			Removable	<input type="text"/>	%
			Sleep Apnea		
			Surgery	<input type="text"/>	%
			Therapy	<input type="text"/>	%
Endodontics			Surgery		
Single Rooted	<input type="text"/>	%	Facial - Elective Cosmetic	<input type="text"/>	%
Multi Rooted	<input type="text"/>	%	Head and Neck	<input type="text"/>	%
Sargenti Root Canal Method	<input type="text"/>	%	Oral/Maxillofacial	<input type="text"/>	%
General Dentistry			Outside oral/maxillofacial region	<input type="text"/>	%
Extractions of Impacted Teeth	<input type="text"/>	%	(describe)	<input type="text"/>	
Oral Surgery (describe)	<input type="text"/>	%	<input type="text"/>		
<input type="text"/>					
Root Canal	<input type="text"/>	%	Jaw	<input type="text"/>	%
Simple Extractions Only	<input type="text"/>	%			

2. Have you performed any implant procedures during the last 12 months?

Yes No

If Yes, answer the following:

(a) Provide the number of procedures performed:

Osseointegration only	<input type="text"/>
Endosteal (surgically inserted into the jawbone)	
Mandibular Multi-quadrant - Ramus Frame	<input type="text"/>
Other	<input type="text"/>
Subperiosteal (lie on top of jawbone but underneath gum tissue)	<input type="text"/>
Transosseus (penetrate entire jaw and emerge opposite the entry site)	<input type="text"/>
Other (describe)	<input type="text"/>

(b) Do your dental records include written notes that a process of patient evaluation occurred prior to treatment? Yes No

(c) Do you perform any surgical procedures, such as sinus lifts, in conjunction with the placement of implants? Yes No

3. Do you render any services outside the scope of your state's Dental Practice Act? Yes No

If YES, describe.

4. Do you use written informed consent documents for all procedures? Yes No

If YES, we will need a copy of all form that are used.

If NO, please explain.

5. Have you ever used a Proplast Viatek TMJ Implant in your practice? Yes No

If YES,

(a) Have all such implants been replaced?

Yes No

(b) What is the date of the last implant?

 / /

6. Do you wire jaws closed for the purpose of weight loss? Yes No

If YES,

(a) Number performed in the last 12 months:

(b) Estimated number that will be performed in the coming year:

7. Do you have a surgical suite? Yes No

If YES, is your surgical suite certified?

Yes No

If YES, provide the name of the certification body.

8. What percentage of your patients are under age 18? %

9. Do you perform any hospital emergency room care? Yes No

If YES, is this solely a requirement for active admitting privileges?

Yes No

If NO, provide a detailed description including the approximate number of hours per month spent in emergency room care.

10. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering dental/medical services, dental/medical opinions or dental/medical advice? Yes No

If YES, provide the following:

(a) Identify all states in which such patients reside:

(b) What percentage of your total practice is involved in such activities? %

11. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? Yes No

If YES, identify all states in which such patients reside.

12. (a) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? Yes No

If YES, do you follow FDA-approved protocols?

Yes No

If YES, describe.

(b) Are you a Principal Investigator for any clinical trial? Yes No

13. (a) Indicate the number of professional employees in your practice for each of the following:

(If none, check here)

Dentists other than yourself Hygienists Surgeon's Assistants* Nurses

<input type="text"/>	Dental Assistants	<input type="text"/>	Physicians	<input type="text"/>	Nurse Anesthetists*
<input type="text"/>	Dental Technicians	<input type="text"/>	Physicians Assistants*	<input type="text"/>	Laboratory/Radiology Technicians
<input type="text"/>	Other (describe) <input type="text"/>				

*Provide a description of duties, in detail, including extent supervised and protocols.

(b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? Yes No

If NO, provide a detailed explanation.

14. (a) Average Weekly patient load: (b) Number of patients annually:

15. Average number of hours you practice each week:

16. (a) Do you supervise anyone other than your own employees? Yes No

If YES, indicate by profession the number of individuals you supervise:

<input type="text"/>	Dentists other than yourself	<input type="text"/>	Hygienists	<input type="text"/>	Surgeon's Assistants*	<input type="text"/>	Nurses
<input type="text"/>	Dental Assistants	<input type="text"/>	Physicians	<input type="text"/>	Nurse Anesthetists*		
<input type="text"/>	Dental Technicians	<input type="text"/>	Physicians Assistants*	<input type="text"/>	Laboratory/Radiology Technicians		
<input type="text"/>	Other (describe) <input type="text"/>						

*Please describe the extent in which you supervise such persons.

Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals.

17. If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: Hospital, Office or Surgi-center.

	Location		Location
<input type="checkbox"/> Acupuncture	Choose One	<input type="checkbox"/> Hair Transplants or Suturing of Hairpieces	Choose One
<input type="checkbox"/> Adenoidectomy/Tonsillectomy	Choose One	<input type="checkbox"/> Laser Skin Resurfacing	Choose One
Anesthesia:		<input type="checkbox"/> Laser Surgery (describe)	Choose One
<input type="checkbox"/> General	Choose One	<input type="text"/>	
<input type="checkbox"/> Twilight	Choose One	Liposuction-above the neck	Choose One
<input type="checkbox"/> Other - (describe)	Choose One	(specify volume) <input type="text"/>	
<input type="text"/>		Liposuction-below the neck:	
Assisting in Surgery:		<input type="checkbox"/> under 3500 cc's volume	Choose One
<input type="checkbox"/> Oral Surgery	Choose One	<input type="checkbox"/> 3500 cc's or more volume	Choose One
<input type="checkbox"/> Other Surgery (describe)	Choose One	<input type="checkbox"/> Nerve Grafts	Choose One
<input type="text"/>		<input type="checkbox"/> Oral/Maxillofacial Surgery	Choose One
<input type="checkbox"/> Biopsies (describe)	Choose One	<input type="checkbox"/> Open Reduction of Fractures	Choose One
<input type="text"/>		<input type="checkbox"/> Pain Management (describe)	Choose One
<input type="checkbox"/> Blepharoplasty	Choose One	<input type="text"/>	
<input type="checkbox"/> Cheek Implant	Choose One	Plastic Surgery:	
<input type="checkbox"/> Chemical Peel:		<input type="checkbox"/> Reconstructive Facial	Choose One
Solution Strength (specify)	Choose One	<input type="checkbox"/> Reconstructive-Other	Choose One
<input type="text"/>		(Please describe)	<input type="text"/>
<input type="checkbox"/> Chin Surgery	Choose One	<input type="checkbox"/> Rhinoplasty	Choose One
<input type="checkbox"/> Cleft Lip and Palate Surgery	Choose One	<input type="checkbox"/> Radiation Therapy	Choose One
<input type="checkbox"/> Cosmetic implantation of silicone or other material	Choose One	<input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	Choose One
<input type="checkbox"/> Cosmetic Surgery	Choose One	<input type="checkbox"/> Sargenti Root Canal Method	Choose One
Cryosurgery		Sinus Lift	

- | | | | | |
|--------------------------|--------------------------------|------------|--------------------------|-------------------|
| <input type="checkbox"/> | | Choose One | <input type="checkbox"/> | Choose One |
| <input type="checkbox"/> | Dental Alveolar Surgery | Choose One | <input type="checkbox"/> | TMJ Surgery |
| <input type="checkbox"/> | Dermabrasion/Microdermabrasion | Choose One | <input type="checkbox"/> | Uvulopalatoplasty |
| Extractions: | | | | |
| <input type="checkbox"/> | Non-Impacted Teeth | Choose One | | |
| <input type="checkbox"/> | Impacted Teeth | Choose One | | |
| <input type="checkbox"/> | Face Lift | Choose One | | |

18. List your prior Professional Liability Insurance for each of the last (5) years, including the current year:

a. Insurance Company: Limits of Liability:
 Effective Date: (MM/DD/YYYY) / / Retro Date: (MM/DD/YYYY) / /
 Claims Made or Occurrence Form:

b. Insurance Company: Limits of Liability:
 Effective Date: (MM/DD/YYYY) / / Retro Date: (MM/DD/YYYY) / /
 Claims Made or Occurrence Form:

c. Insurance Company: Limits of Liability:
 Effective Date: (MM/DD/YYYY) / / Retro Date: (MM/DD/YYYY) / /
 Claims Made or Occurrence Form:

d. Insurance Company: Limits of Liability:
 Effective Date: (MM/DD/YYYY) / / Retro Date: (MM/DD/YYYY) / /
 Claims Made or Occurrence Form:

e. Insurance Company: Limits of Liability:
 Effective Date: (MM/DD/YYYY) / / Retro Date: (MM/DD/YYYY) / /
 Claims Made or Occurrence Form:



Anesthesia Information

1. Is analgesia, sedation or anesthesia used on patients? Yes No

If Yes, answer the following:

(a) Local only Yes No

(b) Inhalation conscious sedation Yes No

If Yes, answer the following:

(i) Percentage of patients under age 18 %

(ii) Drugs used: Nitrous Oxide Other

(iii) Is sedation done in an office, surgi-center or hospital? Choose One -

(iv) Administered by: You Physician Anesthesiologist Dentist Anesthesiologist
 Oral Surgeon CRNA RN/LPN Other:

(c) Oral conscious sedation using drugs that are swallowed Yes No

If Yes, answer the following:

(i) Percentage of patients under age 18 %

(ii) List all drugs used:

(iii) Is sedation done in an office, surgi-center or hospital? Choose One -

(iv) How long have you used conscious sedation in your office or surgical suite?

(v) Administered by: You Physician Anesthesiologist Dentist Anesthesiologist
 Oral Surgeon CRNA RN/LPN Other:

(d) Parenteral conscious sedation (minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacological or non-pharmacological method, or a combination thereof). Yes No

If Yes, answer the following:

(i) Percentage of patients under age 18 %

(ii) List all drugs used:

(iii) Is sedation done in an office, surgi-center or hospital? Choose One -

(iv) How long have you used conscious sedation in your office or surgical suite?

(v) Administered by: You Physician Anesthesiologist Dentist Anesthesiologist
 Oral Surgeon CRNA Other:

(e) Parenteral deep sedation (a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including inability to respond purposely to verbal command, produced by a pharmacological or non-pharmacological method, or a combination thereof). Yes No

If Yes, answer the following:

(i) Percentage of patients under age 18 %

(ii) List all drugs used:

(iii) Is sedation done in an office, surgi-center or hospital? Choose One -

(iv) Administered by: You Physician Anesthesiologist Dentist Anesthesiologist
 Oral Surgeon CRNA Other:

(f) General anesthesia (a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to verbal command, produced by a pharmacological or non-pharmacological method, or a combination thereof). Yes No

If Yes, answer the following:

(i) Percentage of patients under age 18 %

(ii) List all drugs used:

(iii) Is sedation done in an office, surgi-center or hospital? Choose One -

(iv) Administered by: You Physician Anesthesiologist Dentist Anesthesiologist
 Oral Surgeon CRNA Other:

(g) Are Harvard Standards for the administration of all anesthesia adhered to? Yes No

2. (a) Have you completed an ACLS course? Yes No

(b) Do you hold an ACLS certificate? Yes No

If Yes, what is the expiration date? / /

If No, are you currently CPR Certified? Yes No

(c) Is any member of your operating staff currently CPR certified? Yes No

3. Check all that apply:

(a) Have you completed an ADA-accredited general anesthesia program of one year or longer? Yes No

(b) Did your oral surgery training include 6 or more months of training in general anesthesia? Yes No

(c) Have you taken at least two years of anesthesia training following dental school for certification as an anesthesiologist? Yes No

4. Are vital signs of your patients under sedation or general anesthesia continuously monitored?

If Yes, by whom? You CRNA Dentist Anesthesiologist Other:

5. If you use any of the following methods to monitor patients, indicate if you use Sedation, General Anesthesia or Both.

Choose One - Manual monitoring of blood pressure and heart rate.

Choose One - Precordial stethoscope

Choose One - Electronic/automatic monitoring of blood pressure and heart rate

Choose One - EKG monitor

Choose One - Pulse oximeter

Choose One - Other (describe)

6. Which of the following items do you have available for emergency treatment? Check all that apply.

Oral airway Ambu bag Endotracheal tubes/scopes

Oxygen Emergency drugs

7. Does the state you practice in require you to hold a current certificate/permit to administer general anesthesia or intravenous sedation? Yes No

If Yes, provide the following:

Certificate number: Date of renewal: / /



Affiliations

1. Are you in the employ of any individual, firm or corporation other than the employer named in Section 1, 3(a) on page 1? Yes No

If Yes, provide a detailed explanation including a description of your responsibilities.

2. Are you under contract to any individual, firm or corporation other than the contracting entity named in Section 1, 3(a) on page 1? Yes No

If Yes, provide a detailed explanation including a description of your responsibilities.

If Yes, does any contract contain a hold harmless agreement? Yes No

3. Are you in the employ of or under contract to any governmental entity? Yes No

If Yes, provide a detailed explanation including a description of your responsibilities.

4. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? Yes No

If Yes, explain in detail the types of advertisements used.

5. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients? Yes No

If Yes, explain in detail the type of advertisement or applicable website address.

6. Are you the Dental/Medical Director of a nursing home, clinic, commercial enterprise or any other organization? Yes No

If Yes, provide a detailed explanation of any contract or other agreement that describes your position.

7. Do you have any administrative or teaching responsibilities? Yes No

If Yes, provide the following

(a) Name of entity:

Location:

Your title:

(b) Does the entity provide you coverage for:

(i) Your administrative responsibilities and direct patient care? Yes No

(ii) If No, do you require coverage? Yes No

8. Do you work for any locum tenens companies? Yes No

9. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location? Yes No

If Yes, provide details.

10. Are you engaged in or planning to engage in any "moonlighting" activities? Yes No

If Yes, do you want coverage for your "moonlighting" activities?

Yes No

If Yes, describe the activities.

Claims and History

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? yes no

If YES, how many?

2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? yes no

If YES, how many?

3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? yes no

If YES, how many?

4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? yes no

5. Has your license to practice dentistry or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? yes no

6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? yes no

7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? yes no

8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? yes no

9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation,, would limit your ability to safely practice in your medical specialty? yes no

This application, information submitted with this application and all previous application and material changes thereto of which PBS Insurance Underwriting Corporation and affiliates or the Insurance Company receives notice is on file with PBS Insurance Underwriting Corporation or the Insurance Company who is quoting. PBS Insurance Underwriting Corporation and affiliates or the Insurance Company will have relied upon the information within the online application to render a premium indication. If information on the company application materially changes then the company may modify or withdraw any outstanding indication or agreement to bind coverage.

Warranty

I warrant to PBS Insurance Underwriting Corporation and affiliates or the Insurance Company, that I understand and accept the notice stated above and that the information contained herein is true. I authorize the release of claim information from any prior insurer to PBS Insurance Underwriting Corporation and affiliates or the Insurance Company.

You must provide your Name, Title and Today's Date in order to submit this quote request.

/ /

Name of Applicant

Title

Date

Completion of this form does not bind the applicant or PBS Insurance Underwriting Corporation and affiliates or the Insurance Carrier and/or The Underwriting Manager to complete the Insurance.

Notice to Applicants:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

If you should have any additional information to add that would be helpful to better understand your practice and/or situation, please explain below.

Do not submit more than 60 days before your renewal date of present coverage or before the proposed effective date.

If we require additional information what would be the best method to contact you.

- Email Fax
 Regular Mail Phone

If by phone which would be the best time to call:

- AM PM

By typing my name below I certify it as my signature

Type your name here: