CAPITAL INSURANCE SERVICES

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DentistCare Quote Sheet

Business Name: ______________________ FEIN #: ______________

Phone: ______________________ E-Mail: ______________________

Location Address: ______________________ City: __________ State: _____ Zip: __________

Contact Person: ______________________ Phone: ______________ Ext: __________

Limits Requested			
	$100,000 each claim / $300,000 aggregate		$300,000 each claim / $900,000 aggregate
	$200,000 each claim / $600,000 aggregate		$500,000 each claim / $1,000,000 aggregate
	$250,000 each claim / $750,000 aggregate		$1,000,000 each claim / $3,000,000 aggregate

1. Dental Specialty: ______________________ # of hours worked per week: ______________
2. Retroactive Date Requested: ______________
3. Desired type of coverage: ☐ Claims-Made ☐ Occurrence *(where available)*
4. Do you administer: ☐ Local Anesthesia & Nitrous Oxide ☐ Oral Premedication
   ☐ IV/IM Sedation ☐ Conscious Sedation ☐ General Anesthesia
5. Do you perform:
   Oral Surgery: ☐ Minor ☐ Major
   ☐ Surgical placement of implants ☐ Multi-rooted Endodontics
   Extractions: ☐ Partial Bony Impactions ☐ Third Molars ☐ Full Impactions
   ☐ Soft Tissue Surgery ☐ Bone Grafts
6. Do you provide elective facial cosmetic procedures, Botox, collagen injections, or other dermal fillers for cosmetic purposes in your practice? ☐ Yes ☐ No
7. Dental School: ______________________ Year graduated: ______________
8. Current membership(s): ☐ ADA ☐ AGD Member ☐ AGD Fellowship ☐ AGD Mastership

Is your practice a partnership, corporation or LLC? ☐ Yes ☐ No

If yes, name of practice: ______________________ # of Dentists: __________

Loss Information

Have you ever been involved in a malpractice claim or suit? ☐ Yes ☐ No

(If yes, provide a narrative and disposition)

Do you have knowledge of any pending claims or situations which may give rise to claims? ☐ Yes ☐ No

Current Insurance Information

Company Name: ______________ Annual Premium: ______________

Amount Insured for: ______________ Expiration Date: ______________

Procedures performed: *Please complete page 2*

Procedures performed: *Should equal 100%*							
Cosmetic		Intra-oral	%			Extra-oral (Botox/dermal fillers)	%
Oral Surgery		Minor (Alveolar)	%			Major (other procedures)	%
Extractions		Simple	%			Full Impacted	%
		Do you do third molar extractions?				Partial Bony Impacted	%
Implants		Initial Surgical	%			Restorations	%
Endodontics		Single-rooted endodontics	%			Multi-rooted endodontics	%
Prosthodontics		Single unit bridge / crown	%			Multi-unit bridge / crown	%
		Full mouth dentures	%			Denture adjustment and repair	%
Periodontics		Scaling / root planning	%			Soft tissue surgery	%
		Soft tissue grafts	%			Bone grafts	%
Orthodontics		Comprehensive orthodontics	%			Minor tooth guidance	%
Pain Management		Treatment of TMD	%			Other (describe)	
Other		Surgical procedures	%				%
		Non-surgical procedures	%	Describe			%