ELEVATE DENTAL PARTNERS

elevatedentalpartners.com

Name:
Phone number:
Email:
Dental school attended: **Graduation year:**
License number:
LinkedIn or Facebook:

SECTION 1 - WORK EXPERIENCE

(If you are a new grad, please skip ahead to Section 2.)

Work Experience

Please list all dental positions held with names and locations of practices:

List all CE courses taken in the last 2 years

Please include location and name of course, whether in person, hands on, text or web based:

Are you currently a member of any local or national study clubs?

Please list and describe:

SECTION 2 - OWNERSHIP

Do you want to or have you ever owned a dental practice?

Most **rewarding** thing about owning your own practice?

Most **challenging** thing about owning your own practice?

SECTION 3 - EXPECTATIONS

Describe your ideal dental office:

Where do you see yourself professionally in 5 years?

What excites you most about dentistry?

What are the biggest challenges you have with dentistry?

Describe your treatment assessment protocol and philosophy for a new patient exam:

What's something that excites you about our organization and/or dental practice?

What's something that gives you pause about our organization or practice?

SECTION 4 - SKILLSET AND EXPERIENCE

Please read over the following list of dental services and mark the appropriate number next to each service or treatment to indicate the following:

4 I have experience and feel confident doing this treatment at a high level.

3 I have some training or certification but with limited experience. I am actively developing this skillset but am not where I aim to be.

2 I have limited training and/or no certification but would attempt procedure under direct supervision or mentorship.

1 I have limited or no training but aspire to add this procedure to my skillset eventually.

0 I have no plans or desire to ever perform this treatment.

Pediatric dentistry	_____	Sleep dentistry	_____
Simple extractions	_____	Crown Lengthening	_____
Surgical extractions	_____	Perio Surgery	_____
Partial bony 3rds	_____	Implants	_____
Full bony 3rds	_____	Implant restoration	_____
Inlays/Onlays	_____	Implant dentures	_____
¾ Crowns	_____	Dentures	_____
Bridges	_____	Socket grafting	_____
Anterior endo	_____	All on 4 placement	_____
Molar endo	_____	All on 4 restoration	_____
Conventional ortho	_____	Full mouth rehab	_____
Invisalign	_____	Oral Sedation	_____
Veneers	_____	IV Sedation	_____

SECTION 5 - HOURS AND WORK EXPECTATIONS

Please read over the following list and mark the appropriate number next to each element of business or practice to rate your willingness:

4 • Excited and willing

3 •

2 • Neutral and willing

1 •

0 • Not willing or able

PPO dentistry	_____	5 days a week practice	_____
FFS dentistry	_____	4 days a week practice	_____
Medicaid dentistry	_____	3 day or less practice	_____
On call for emergencies	_____	Communication coaching	_____
Late night hours	_____	Clinical coaching	_____
Early morning hours	_____	Production tracking	_____
Weekend hours	_____	Patient acceptance tracking	_____
Community service/ Volunteering	_____	Post op patient phone calls	_____
Donations/Charitable contributions	_____	Marketing photo/video and social media	_____

Please submit this completed form to ElevateDentalPartner@gmail.com