DENIS Network Application Form

Please complete this form in full and forward to DENIS

Fax: 0866 770 336
E-mail: thenetwork@denis.co.za

DENIS will maintain the confidentiality of the information you provide on this form unless the disclosure thereof is required by law. If your application is successful, the information supplied on this application form will become part of your DENIS Network records. Once your application is processed, you will be informed of the outcome of the application

Practitioner's/Practitioners' Details

Full Name					
Practice Number					
Health Professions Council Number		DPA Yes/No	SADA Member Yes/No	DENTASA Yes/No	OHASA Yes/No
Professional Indemnity Number (*where applicable)*					
Practice's VAT registration Number					

Names and HPCSA numbers of all dentists, locums, dental therapists and oral hygienists in the practice, who claim under this practice number:		
1.		
2.		
3.		
4.		
Are all practitioners in your practice(s) compliant with the HPCSA's CPD requirements	Yes	No

Practice Details

Physical Address [where practice is situated]				
			Postal Code	
Postal Address				
			Postal Code	
Practice Telephone Number		Fax Number		
Practice E-mail Address		Cell phone number		
Practice Management Details				
Physical address (If the same as above, please indicate that):			Postal code	
Postal Address of practice management:			Postal code	
Practice management telephone number:		Fax number		

Dental Information Systems (Pty) Ltd
T +27 21 528 5300 | F +27 86 677 0336
Block D, The Forum, Northbank Lane, Century City, 7441 | PO Box X1, Century City, 7446
Reg no: 1996/000371/07 | *a member of the EOH Group of Companies*
www.eoh.co.za

an EOH company

Directors: JW King, PAP Leroy, DC Carolus, HL Nhlapo

Practice management email address		Cell phone number	
Do you have satellite (additional) practices?		YES	NO
Please list the satellite practice details where applicable:			
Satellite Practice Address [where practice is situated]			
		Postal Code	
Satellite Practice telephone number		Fax Number	

Satellite Practice Address [where practice is situated]			
		Postal Code	
Practice Telephone Number		Fax Number	
Do you send laboratory work outside of your practice?		Yes	No
If yes, please supply the laboratory details:			
Laboratory Number			
Laboratory Address			
		Postal Code	
Registration Number		Practice Number	
Identification Number			
VAT Registration No			
Telephone Number			

Please indicate your preferred method of claim submission	Online	EDI	Paper	
Please indicate your preferred method of communication	Email	Post	Phone	SMS
Please specify the IT Practice Management System currently used in your practice:				
Does your practice have a card reader facility		Yes		No
Is your practice associated with any other dental network or organisation? Name of relevant network or organisation:		Yes		No
Practice Facilities				
IV Sedation			Yes	No
X Ray Unit			Yes	No
If yes, X-ray license number				
Do you accept after hours emergencies			Yes	No
Method of instrument sterilisation			Autoclave	Other

Practice Capacity	
Kindly indicate the average number of patients seen per day according to the following classifications:	
Private	
Medical Aid	
Kindly indicate the distance of your practice from a public transport depot:	km

I...hereby declare that all information submitted is true and correct. I understand that the information that I have provided is subject to verification. I acknowledge and agree that the acceptance of my application is at the sole discretion of DENIS.

Signed	
Date	