



DENIS Network Application Form

Please complete this form in full and forward to DENIS

Email: 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.

Practitioners' Details

Full Name:

Practice Number:

HPCSA Number:

Professional Indemnity Number (where applicable):

Practice VAT Registration Number:

Are you a member of any of the following professional associations:

DPA Yes No SADA Yes No DENTASA Yes No OHASA Yes No

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.

5.

6.

7.

8.

Are all practitioners in your practice(s) compliant with the HPCSA's CPD requirements? Yes No

Dental Information Systems (Pty) Ltd

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Reg no: 1996/000371/07

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Directors: JW Boonzaier, DC Carolus, AA Mahmood, HL Nhlapo, GN Van Wyk

Practice Details

Physical Address *[where practice is situated]*:

Postal Code:

Postal Address:

Postal Code:

Practice Telephone Number:

Fax Number:

Cell Phone Number:

Practice Email Address:

Do you have satellite/additional practices?

Yes

No

If yes, please list the satellite/additional practice details where applicable

A. Satellite Practice 1: Physical Address *[where practice is situated]*:

Postal Code:

Satellite Practice Telephone Number:

Fax Number:

B. Satellite Practice 2: Physical Address *[where practice is situated]*:

Postal Code:

Satellite Practice Telephone Number:

Fax Number:

C. Satellite Practice 3: Physical Address *[where practice is situated]*:

Postal Code:

Satellite Practice Telephone Number:

Fax Number:

D. Satellite Practice 4: Physical Address *[where practice is situated]*:

Postal Code:

Satellite Practice Telephone Number:

Fax Number:

E. Satellite Practice 5: Address *[where practice is situated]*:

Postal Code:

Satellite Practice Telephone Number:

Fax 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:

Cell Phone Number:

Practice Management Email Address:

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?

Yes

No

If yes, name of relevant network of organisation:

Practice Facilities

X-ray Unit

It is a prerequisite to have the following at the dental practice when applying to join the DENIS Dental Network: **A licensed X-ray machine or proof of purchase of an X-ray unit.**

Is the X-ray unit registered in the applicant's name?

Yes

No

If yes, kindly attach the Department of Health (DoH) approved X-ray licence certificate or proof of purchase.

If no, please provide the following information:

Practice number of the owner of the machine at the dental practice

Practice Number

HPCSA Registration Number

X-ray Licence Number*

**Please attach the Department of Health (DoH) approved X-ray licence certificate.*

Practice Facilities

IV Sedation

Yes	No
Autoclave	Other

Method of instrument sterilisation

Do you send laboratory work outside of your practice?

Yes	No
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If yes, please supply the laboratory details

Laboratory Number:

Laboratory Address:

Postal Code:

Registration Number:

Practice Number:

Identification Number:

VAT Registration Number:

Telephone Number:

Practice Capacity

Do you accept after hours emergencies?

Yes	No
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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