



LAMP Services Limited

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DENTAL IMPLANT AFTER CARE DENTIST APPLICATION FORM

Dentist Name:

Practice Name:

Address:
Postcode:

Tel No: **Fax No:**

Email:

Key Contacts:	1	2
Name:	<input type="text"/>	<input type="text"/>
Position:	<input type="text"/>	<input type="text"/>
Email:	<input type="text"/>	<input type="text"/>

GDC No: **Year Qualified:**

List of Qualifications:

GDC Specialist Listings:

No. Years Placing Implants: **Total Implants Placed (approx.):**

Average No. Implants Placed (Monthly):

Approximate success rate:

No. patients requiring: **Repair**
Replacement

Implant system(s) used: **Tooth Numbering System:**

Professional indemnity provider

Have you received any claims which have resulted in payment to a claimant of complaints which have been upheld by the GDC? Yes / No (please delete) If yes, please attach details separately.

PTO

Please complete either section 1 or 2:

Section 1

If you will be including Dental Implant After Care in your patient's treatment plans and wish to be billed monthly, please complete the following:

I _____ (dentist) wish to apply for Dental Implant After Care to pass on cover and certify the above information to be true.

Signed

Date.....

Or

Section 2

If you wish only to display Dental Implant After Care leaflets in your practice, and for your patients to apply and pay for the cover directly, please complete the following:

I _____ (dentist) certify the above information to be true.

Signed

Date.....