

**Form C – Supplement to Application**

**Supplemental Questionnaire for Dental Related Fields**

1. a. Do you administer general anesthesia? Yes \_\_\_ No \_\_\_
- b. If "YES", where is the anesthesia administered? Office \_\_\_ Hospital \_\_\_  
Surgical Center \_\_\_\_\_ Other \_\_\_\_\_
- c. Do you administer intravenous or intramuscular sedation? Yes \_\_\_ No \_\_\_  
If "YES", please list the drugs you utilize for this purpose. \_\_\_\_\_  
\_\_\_\_\_
- d. Do you ever render the patient unconscious? Yes \_\_\_ No \_\_\_ If "YES", provide names of anesthetics used and quantities in which they are usually administered.  
\_\_\_\_\_  
\_\_\_\_\_
- e. Do you supervise CRNAs? Yes \_\_\_ No \_\_\_ If "YES", where do you supervise the CRNAs? Office \_\_\_ Hospital \_\_\_  
Surgical Center \_\_\_ Other \_\_\_\_\_
- f. Do the CRNA/CRNAs carry separate liability insurance? Yes \_\_\_ No \_\_\_  
If "YES", please provide a photocopy of the insurance policy.
- g. Do you perform dentistry on patients who have been administered general anesthesia?  
Yes \_\_\_ No \_\_\_
- h. Do you use nitrous oxide or any other anesthetic as an "analgesic" where patients *are not* rendered unconscious?  
Yes \_\_\_ No \_\_\_ If "YES", provide names of anesthetics used: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- i. Are you fully trained in CPR? Yes \_\_\_ No \_\_\_  
When Certified \_\_\_\_\_ When Recertified \_\_\_\_\_
- j. Have you received any training in intubation? Yes \_\_\_ No \_\_\_
- k. Do you employ a Dental Hygienist? Yes \_\_\_ No \_\_\_ If "YES", does the Dental Hygienist provide his/her own liability insurance? Yes \_\_\_ No \_\_\_
- l. Do you always directly supervise the Dental Hygienist? Yes \_\_\_ No \_\_\_
2. a. Do you perform any reconstructive surgery? Yes \_\_\_ No \_\_\_  
If "YES", explain in detail? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_