

Dentist Insurance Quote Sheet

Name: _____ DDS / DMD

Entity Name: _____ FEIN #: _____

Location Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

PROFESSIONAL LIABILITY			
Liability Limit:	\$1 mil / \$3 mil	\$2 mil / \$4 mil	
	\$3 mil / \$6 mil	Other: _____	
What type of policy do you have?	Claims-made	Occurrence	
If claims-made, what is the retroactive date?	_____		
Current Carrier:	_____ Exp. Date: _____		
What is your Dental Specialty?	_____		
When did you graduate from Dental School? (month/year)	_____		
What date did you begin practicing dentistry?	_____		
How many hours per week do you practice dentistry?	_____		
Will you be administering Intravenous and/or Intramuscular conscious sedation?	YES	NO	
Will you be performing the following procedures?			
Full and/or Partial Bony Impacted teeth extractions?	YES	NO	
Surgical placement of implants?	YES	NO	
DISCOUNT ELIGIBILITY:			
Are you a member of the:			
American Dental Association (ADA)?	YES	NO	
National Dental Association (NDA)?	YES	NO	
Hispanic Dental Association (HDA)?	YES	NO	
Academy of General Dentistry (AGD)?	YES	NO	
If Yes, are you an AGD	Member	Fellowship	Mastership

BUSINESS PERSONAL PROPERTY			
Amount of Business Personal Property? (furniture, medical and office equipment, etc.)	\$ _____		
Deductible:	\$500	\$1000	\$2500 \$5000
Amount of Computer Equipment? (software, hardware, laptop, etc.)	\$ _____		
Current Carrier:	_____ Exp. Date: _____		

Date: _____

LOCATION INFORMATION	
Do you own the Building or Commercial Condo?	YES NO
Is a separate entity set up to own the building?	YES NO
If Yes, Name:	_____
If you are responsible for insuring the building, how much? \$	_____
If you are responsible for cost of Tenant Improvements, how much? \$	_____
Building Construction:	Frame/Stucco Brick/Block
	Other: _____
Approx. Year Built:	_____ Office sq.ft: _____ # of Stories: _____
Safety Features:	Sprinklers Central Station Burglar Alarm
	Central Station Fire Alarm
Estimated Annual Gross Revenue: \$	_____

GENERAL LIABILITY					
Type:	Sole Proprietor	Partnership	Corp.	LLC	Other
Liability Limit:	\$1 mil / \$2 mil	\$2 mil / \$4 mil			
Umbrella:	\$1 mil	\$2 mil	\$5 mil	\$10 mil	None

WORKERS COMPENSATION			
Number of Full-time Employees:	_____	Part-time:	_____
Total Annual Payroll: \$	_____		
Coverage for the Owner(s):	Include	Exclude	
If Excluded, does your Health Insurance Policy cover you for work related injuries?	YES	NO	
Employer's Liability Limit:	\$100,000	\$500,000	\$1,000,000
Current Carrier:	_____ Exp. Date: _____		

CLAIMS INFORMATION	
Any Claim reported on your professional liability, property, general liability or workers compensation policy in the last 10 years?	YES NO
If Yes, please describe:	_____

May we email quotes, policies, and related coverage documents to you? _____ YES NO

Signature: _____

WE CAN WRITE PROPERTY AND GENERAL LIABILITY WITH OR WITHOUT PROFESSIONAL LIABILITY.

Fax completed form to **866.467.3611** or save pdf and email to info@desertmountaininsurance.com
 Submitting completed form works best from desktops. On mobile devices/tablets: **MUST OPEN** in Adobe Acrobat Reader App.
 (Download free Adobe Acrobat Reader from the App Store or Google Play Store.)

For questions, please call:
866.467.3627



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