

ALBUQUERQUE SURGERY CENTER

Delineation of Privileges - *Dental*

Please indicate by a check in the requested column those privileges that are commensurate with your clinical ability, training and experience for which you are applying.

PRIVILEGES:	Requested	Not Requested	Approved	Denied
Evaluation and diagnosis of medical conditions to determine need for surgical intervention.				
Restorative dental procedures, to include operative dentistry and crown and bridge.				
Exodontia to include simple nonsurgical removal of teeth, immediate dentures, alveoplasty, cystectomy, osseous surgery, and biopsy.				
Endodontics, to include nonsurgical procedures				
Prosthetics, to include the prosthetic phase of implants				
Oral prophylaxis, not to include gingivectomy, mucogingival surgery, or periodontal surgery.				
Oral Surgery				
Routine forcep extraction of primary or permanent teeth				
Surgical removal of erupted teeth				
Surgical removal of soft tissue impacted teeth				
Alveolectomy				
Mucogingival extension				
Alveoplasty of alveolar ridges				
Apicoectomy, with or without root canal therapy				
Enucleation of small cysts (under 2 cm)				
Frenectomy (labial or lingual)				
Incision and drainage (intraoral)				
Surgical removal of partially bony impacted teeth				
Surgical removal of full bony impacted teeth				
Surgical exposure of crown of impacted tooth (for orthodontic therapy)				
Alveolar ridge extension (maxillary or mandibular)				
Closed and open reduction of fractures of the facial bones				
Enucleation of large cysts of the jaw				
Excision of benign hard and soft tissue lesions of the jaws and contiguous structures				
Excision of mucocele				

Do you anticipate giving local anesthesia?

Yes No

Do you anticipate administering your own anesthesia?

Yes* No

Do you administer anesthesia at any other local facilities?

Yes No

(*If yes, please complete Anesthesia Privileges for non-anesthesiologists.)

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Your initials as used in Medical Records _____

Your signature as used in Medical Records _____

I, _____, hereby request privileges in the specialty of **Dentistry** as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

Physician

Date

APPROVAL:	
Comments:	

_____	_____
Medical Director/President, Medical Staff	Date