Growing Healthy Smiles
PEDIATRIC DENTISTRY
2013 Town Center Blvd.
Fleming Island, FL 32003
904-215-7800
TeamKailes.com

APPLICATION FOR EMPLOYMENT

Beth E. Kailes, D.M.D., P.A. does not discriminate against applicants on the basis of race, sex, color, religion, national origin, age, disability, or veteran status. We are an Equal Opportunity Employer.

Date: _____ How did you hear about this position? _____

Have you applied to/worked for this company before? ☐ No ☐ Yes - When:_____

Have your children ever been or are currently patients in our office? ☐ No ☐ Yes

PERSONAL INFORMATION

Name: _____
Last First Middle

Address: _____
Street

_____
City State Zip Code

Phone number: _____ Cell phone: _____

Email address: _____ Position applying for: _____

Estimated Distance/travel time from home to our office:_____

Available to work: ☐ Part time ☐ Full time

Can you work these hours 4 days/week? **7:30am-5:30pm with one shift per month of 6am-5pm**

☐ Yes ☐ No

What days are you **NOT** available to work? ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

What hours are you available to work? _____

Desired Salary: _____ Desired Benefits: _____

Date Available to Start: _____

Have you ever been convicted of a felony or criminal offense, including driving under the influence of alcohol or drugs, but excluding minor traffic violations and parking tickets? ☐ Yes ☐ No
If yes, please explain: _____

EMERGENCY CONTACT INFORMATION

1. _____ _____ _____
Name Relationship Phone number(s)

2. _____ _____ _____
Name Relationship Phone number(s)

EDUCATION:

Education	Name of School	Dates Attended	Degree or Certificate Earned
High School			
College			
Other			

Specialized Training/Certifications: ☐ Xray ☐ RDA/CDA ☐ Expanded Duty

☐ Other:_____

Seminars & C.E. Courses Attended: _____

_____

WORK HISTORY: (most recent)

Employer: _____ Dates Employed: From_____ To_____

Address: _____

Supervisor: _____ Phone: _____

Position: _____ Starting Pay Rate: _____ Final Pay Rate: _____

Duties: _____

Reason for leaving:_____

May we contact this employer? ☐ Yes ☐ No

Employer: _____ Dates Employed: From_____ To_____

Address: _____

Supervisor: _____ Phone: _____

Position: _____ Starting Pay Rate: _____ Final Pay Rate: _____

Duties: _____

Reason for leaving:_____

May we contact this employer? ☐ Yes ☐ No

PROFESSIONAL SKILLS:

BUSINESS:	YES	NO	Number of Years	Last Yr. Used	CLINICAL:	YES	NO	Number of Years	Last Yr. Used
Appointment Scheduling					Charting				
Scheduling/Filing Oral Sedations					Clinical Notes				
Scheduling/Filing IV Sedations					Traditional Xrays				
Filing Electronic Claims					Digital Xrays				
Filing Paper Claims					Panoramic Xrays				
Insurance Verification					Coronal Polishing				
Insurance Payments & EOBs					Scaling Above the Gumline				
Data Entry					Sterilization				
Scanning					Operatory Sanitation & Setup				
Patient Check-in					Patient Education Preventive				
Patient Check-out					Patient Education Post Op				
Operating Recall System					Operative Assisting				
Treatment Presentation					Operative Assisting Pedo				
Making Financial Arrangements					Applying Sealants				
Collecting Delinquent Accounts					Taking Impressions				
Resolving Patient Conflicts					Creating Treatment Plans				
Chartless/Paperless Office					Special Needs Patients				
Other:					Other:				

What computer software are you proficient with? _____

What dental software are you proficient with? _____

Do you prefer working in the front office or the clinical office? _____

Are you willing to be cross-trained to work where needed (business/clinical office)? ☐ Yes ☐ No

REFERENCES: (Please list three people not related to you that you have worked with)

Name: _____ Years Acquainted: _____

Telephone: _____ Address: _____

How do you know this person?: _____

Name: _____ Years Acquainted: _____

Telephone: _____ Address: _____

How do you know this person?: _____

Name: _____ Years Acquainted: _____

Telephone: _____ Address: _____

How do you know this person?: _____

PERSONAL

How would you describe your personality?

_____

_____

What would you consider to be your greatest strengths?

_____

_____

What are two of your weaknesses?

_____

_____

What kind of people irritate you? What are your pet peeves?

_____

_____

In your previous positions, what duties did you enjoy the most and why?

_____

_____

In your previous positions, what duties did you enjoy the least and why?

_____

_____

What new skills would you like to learn?

_____

_____

How many days were you absent from work last year and why?

_____

_____

In a team environment, what role do you usually take on?

_____

_____

How would you feel about working beyond your normal working schedule to treat a patient?

_____

_____

How would you deal with a nervous or scared patient?

_____

_____

Where do you see yourself in 5 years professionally and personally?

_____

APPLICANT'S STATEMENT

I grant the permission to Dr. Beth E. Kailes, D.M.D., P.A. or its duly authorized representatives to conduct a background check, credit check and to contact any persons, companies, schools, or healthcare providers named or referred to in the application (other than my present employer) and hereby authorize those persons, companies, schools, and healthcare providers to provide my record, reason for leaving, and all other information they have concerning me to the Practice. I further release all such parties and Beth E. Kailes, D.M.D., P.A. from any and all liability claims for damage whatsoever that may result from such contact or information.

The information given by me in this application is true and complete, and I agree that if the information is found to be false or misleading, that I will be disqualified from consideration for employment or subject to immediate dismissal if discovered after I am hired.

Signature of Applicant: _____ Date: _____

Please review the following information about this position – if the position or hours are not suitable for you, please do not apply.

POSITION: Full-time Pediatric Dental Assistant

Responsible for greeting patients/parents, reviewing medical history, charting, all clinical notes, taking digital xrays (PAs, BWX, Pano), performing coronal polishing & scaling above the gumline, flossing, applying fluoride varnish, creating treatment plans, educating patient/parent about oral hygiene care & treatment, charging services to accounts, discharging patients, assisting chairside for resin composite fillings, pulpotomies, pulpectomies, stainless steel crowns, resin crowns, extractions, impressions, seating appliances, nitrous oxide, oral sedation, IV sedation; making post-op phone calls, calling patients to schedule appointments, sterilizing instruments, disinfecting patient operatories, basic cleaning duties, basic front office duties including answering phones, checking patients in/out, scanning, data entry, filing, etc.

POSITION: Full-time Pediatric Dental Receptionist

Responsible for checking patients in/out, answering phones, scanning, data entry, filing, insurance verifications, scheduling appointments, resolving accounts, processing payments, opening/closing the front office, presenting treatment plans, providing above & beyond customer service with every interaction.

HOURS: 4 Days a week (would not be Saturdays or Sundays), approx. 35-40 hours per week 7:30am-5:30pm (1 hour lunch break); one early shift per month of 6:00am-5:00pm

BENEFITS:

After 90 Days: Paid Holidays, Discount for Dental Services (dependent children only), Medical/ Dental Insurance Reimbursement up to $175/month (private plan only)

After 1 Year: Paid Personal Hours to Full Time Employees , Retirement Account (employer matching)

PLEASE RETURN COMPLETED APPLICATION ALONG WITH YOUR RESUME:

EMAIL: Smile@TeamKailes.com **FAX:** (904) 215-7887

MAIL/DROP OFF: 2013 Town Center Blvd. Fleming Island, FL 32003

Beth E. Kailes, DMD, PA - Pediatric Dentistry
Tobacco-Free Workplace Policy

A tobacco-free environment helps create a safe and healthy workplace. Smoking and secondhand smoke are known to cause serious lung diseases, heart disease and cancer. Beth E. Kailes, DMD, PA recognizes the hazards by tobacco use and exposure to secondhand tobacco smoke. Our policy to provide a tobacco-free environment for all employees and visitors was established to keep a safe and healthy workplace environment. This policy covers the smoking of any tobacco product and the use of oral tobacco products, “spit" tobacco and e-cigarettes, and it applies to both employees and non-employee visitors of Beth E. Kailes, DMD, PA.

Policies

COMPLETE TOBACCO-FREE POLICY

No use of tobacco products including cigarettes and “spit tobacco” or e-cigarettes is permitted within the facilities or on the property of Beth E. Kailes, DMD, PA at any time.

Procedure

1. Employees will be informed of the Beth E. Kailes, DMD, PA Tobacco-free Policy through signs posted throughout properties owned and operated by Beth E. Kailes, DMD, PA, including company owned vehicles.

2. Visitors will be informed of the Beth E. Kailes, DMD, PA Tobacco-free Policy by their hosts, the meeting invite, email correspondences and signs posted throughout the properties owned and operated by Beth E. Kailes, DMD, PA.

3. Beth E. Kailes, DMD, PA will help employees who want to quit smoking by helping them access recommended smoking cessation programs and materials. (Visit www.lung.org/stop-smoking for more information.)

4. Any violations of this policy will be handled through the standard disciplinary procedure, including possible immediate termination of the employee.

By signing this form, I agree to adhere to this policy at all times. I understand that the use of any and all tobacco related products are strictly prohibited as described in the policy and that the use of these products will nullify my eligibility of employment and may result in immediate termination of employment.

_____

Applicant/Employee Name - Printed

_____ _____

Applicant/Employee Signature DATE

EMPLOYMENT REFERENCE AND BACKGROUND CHECK AUTHORIZATION TO RELEASE INFORMATION

As an applicant for employment with Beth E. Kailes DMD, PA dba Growing Healthy Smiles

for the position of _____, I hereby authorize:

A.) My previous/current employers to provide verification of my employment and opinions/comments of my ability and general qualifications to the company listed above. I hereby release the above companies and educational institutions from any liability for any damage whatsoever resulting from the giving of such information as may be requested, and specifically authorize the release of such information.

B.) The company listed above or person acting on their behalf to communicate with my former employers and educational institutions which I have attended concerning my employment/attendance there, and to make an independent investigation of my character, conduct and credit record; and to keep and preserve confidential records of such investigations.

C.) The company listed above and its designated agents or representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records. I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge all information, verbal or written, pertaining to me. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. I hereby release the company listed above and it's designated agents, the Social Security Administration, and its agents, officials, representative, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release.

Applicant Name: _____ Date: _____

Social Security #: _____

Date of Birth (for Criminal Background Check purposes only): _____

Applicant Signature: _____