Dental Practice-Based Research Network

Dear Colleague:

As part of a major effort to lead the nation in advancing dental practice-based research, we would greatly appreciate it if you would complete this questionnaire.

This questionnaire will help us establish the "Dental Practice-Based Research Network", which will be a consortium of participating practices and dental organizations who are committed to advancing knowledge of dental practice and ways to improve its efficiency or effectiveness. Each participating practice will receive a summary of the findings from this questionnaire. The administrative base for the network will be at the University of Alabama at Birmingham (UAB) School of Dentistry.

We estimate that completing this survey will take about 30 minutes. Your office staff may be able to answer some of these questions.

After completing the questionnaire, you may be contacted regarding research projects that the network might implement at some point in the future. Records of your participation in this study will be kept confidential. Only authorized personnel will have access to data, and all information, whether electronic or in paper form, will be stored in a secure manner. This information will not be sold, used for any reason other than research, released to any insurance company, or released to any other similar interest. Although UAB's Institutional Review Board (IRB) has already reviewed and approved the questionnaire, it has the authority to inspect completed questionnaires to ensure that we have complied with IRB procedures. Results may be published for scientific purposes, but your identity will not be revealed. Only statistical summaries will be presented.

If you have questions about your rights as a research participant, you may call Ms. Sheila Moore, Director of the IRB. Ms. Moore's phone number is (205) 934-3789 or 1-800-822-8816, press option #1 and ask the operator for extension 4-3789 (Monday through Friday, 8 AM to 5 PM).

THANK YOU! If you have any questions, please call Andrea Mathews, Program Manager for this project at (205) 934-2578.

With regards,
Gregg H. Gilbert, DDS, MBA, FAAHD
Professor and Chair Department of Diagnostic Sciences School of Dentistry
Please fill in your name and office information, and today's date. Be assured that results will be reported only as statistical summaries, with no personal identifiers. If you practice at more than one office, please record those offices, too.

US Dentists Enrollment Form

The purpose of this form is to enroll dentists in the Dental Practice-based Research Network. The enrollment form consists of thirty-two questions, which have been divided into five sections (Contact Information, Practitioner Characteristics, Practice Characteristics, Patient Population Characteristics, & Future Research Projects). It takes approximately 30 minutes to complete this form.

Please fill in your name and office information. Be assured that results will be reported only as statistical summaries, with no personal identifiers. If you practice at more than one office, please record those offices, too.

Section 1: Contact Information:

Today's date: ________________________

Prefix: (e.g., DR, MR, MS) ________________________
First Name: ________________________
Middle Name: ________________________
Last Name: ________________________
Suffix: (e.g., Sr., Jr.) ________________________
Degree: (e.g., PhD, DDS) ________________________
Email address: ________________________

Name of Practice: Site 1 ________________________
Address line 1: ________________________
Address line 2: ________________________
City: ________________________
State: ________________________
Zip code: ________________________
Country: ________________________
Office phone number: ________________________
Alternative phone number: ________________________
Fax number: ________________________
Assistant: First Name ________________________
Assistant: Last Name ________________________
Assistant: Email ________________________

Name of Additional Practice: Site 2 ______________________________
Address line 1: ______________________________
Address line 2: ______________________________
City: ______________________________
State: ______________________________
Zip code: ______________________________
Country: ______________________________
Office phone number: ______________________________
Alternative phone number: ______________________________
Fax number: ______________________________
Assistant: First Name ______________________________
Assistant: Last Name ______________________________
Assistant: Email ______________________________

Name of Additional Practice: Site 3 ______________________________
Address line 1: ______________________________
Address line 2: ______________________________
City: ______________________________
State: ______________________________
Zip code: ______________________________
Country: ______________________________
Office phone number: ______________________________
Alternative phone number: ______________________________
Fax number: ______________________________
Assistant: First Name ______________________________
Assistant: Last Name ______________________________
Assistant: Email ______________________________

Section 2: Practitioner Characteristics: [Questions 1 - 8]
Unless otherwise stated in the question, please provide one answer for each question.

1. Do you practice as a general dentist or as a specialist? Please select the appropriate answer.

1. General Practitioner
2. Oral/Maxillofacial Surgeon
3. Periodontist
4. Prosthodontist
5. Endodontist
6. Pediatric Dentist
7. Orthodontist
8. Other (please specify) ____

2. What is your gender?

1. Male
2. Female

3. What is your age? _______________

4. What is your racial identification?

1. White
2. Black or African-American
3. American Indian or Alaska Native
4. Asian
5. Native Hawaiian or Other Pacific Islander
6. Other (please specify) ____

5. Are you of Hispanic or Latino origin?

1. Yes
2. No

6. In which of the following dental organizations are you currently a member? (Check all that apply)

1. American Dental Association/state dental association/local association
2. Academy of General Dentistry/state academy of general dentistry
3. Other (please specify) ____
4. Other (please specify) ____
5. Other (please specify) ____
6. Other (please specify) ____
7. Other (please specify) ____

8. None

7. What year did you graduate from dental school? _____________

8. From which dental school did you graduate? ____________________________________

Section 3: Practice Characteristics: [Questions: 9-19]

NOTE: IF YOU PRACTICE AT MORE THAN ONE LOCATION, PLEASE INCLUDE ALL THESE LOCATIONS WHEN ANSWERING THE FOLLOWING QUESTIONS.

9. Which one of the following BEST describes your practice arrangement?

1. Employed by another dentist
2. Self-employed without partners and without sharing of income, costs, or office space (one type of solo practice)
3. Self-employed without partners but share costs of office and/or assistants, etc (but with no income-sharing arrangements; another type of solo practice)
4. Self-employed as a partner in a complete partnership (both income and expenses shared) Including you (the dentist), how many partners are there in the practice? __________ partners in the practice
5. Other (please specify)____

10. At how many dental sites, clinics, or hospitals do you provide direct patient care (excluding teaching, consulting or management) at least once each week?

1. One
2. Two
3. Three
4. More than three

11. Do you practice full-time or part-time (including all sites at which you are practicing)?

1. full-time (32 or more hours per week)
2. part-time (less than 32 hours per week)

12. How many hours per week do you personally spend in direct patient care, as opposed to management or teaching responsibilities (including all sites at which you are practicing)?

_________ hours in patient care

13. How many people (including yourself) in your part of the practice work full-time or work part-time (including all sites at which you are practicing)?
[Note: If you and another dentist share equally a receptionist, then count that employee as ½ of an employee.]

	full-time employees (32+ hours/week)	part-time employees (less than 32 hours/week)
dental hygienists	_________	_________
dental assistants	_________	_________
lab technicians	_________	_________
office manager, receptionist, other office personnel	_________	_________

14. How many dental chairs do you, your assistant(s), and hygienist(s) use regularly in your part of the practice (including all sites at which you are practicing)?

_________ dental chairs

15. How many patient visits do you personally (excluding your hygienist's patients) have during a typical work week (including all sites at which you are practicing)?

_________ patient visits in a typical week

16. Approximately what percentage of your patients have extended payment schedules? If you do not accept extended payment schedules, please record 0% in the column.

_______________ %…of patients on extended payment schedules (e.g., monthly payments)

17. On average, how long does a patient in your practice have to wait:

1. for a new patient exam appointment ________ days
2. for a treatment procedure appointment ________ days
3. In the waiting room after arriving for an appointment ________ minutes

18. Which of the following best describes your part of the practice during the past 12 months?

1. Too busy to treat all people requesting appointments
2. Provided care to all who requested appointments, but the practice was overburdened
3. Provided care to all who requested appointments, and the practice was not overburdened
4. Not busy enough - the practice could have treated more patients

19. Please record what your typical fee is for a ...

		Please check below if you do **not** do this procedure
2-surface amalgam (ADA 2150)	$ ____________	_______
3-canal molar root canal (ADA 3330)	$ ____________	_______
Single simple/uncomplicated extraction	$ ____________	_______

(ADA 7140)		
Cast partial denture (ADA 5213 or 5214)	$ ____________	_______
Full denture (ADA 5110 or 5120)	$ ____________	_______
Porcelain-to-metal crown (average of ADA 2750, 2751, 2752)	$ ____________	_______
1-surface posterior composite (ADA 2391)	$ ____________	_______
2-surface anterior composite (ADA 2331)	$ ____________	_______

Section 4: Patient Population Characteristics: [Questions: 20-31]

NOTE: IF YOU PRACTICE AT MORE THAN ONE LOCATION, PLEASE INCLUDE ALL THESE LOCATIONS WHEN ANSWERING THE FOLLOWING QUESTIONS.

20. Approximately what percentage of the patients in your practice scheduled with you are ... ?

Children & Teenagers (1 to 18 years) _______________ %
Young adults (19 to 44 years) _______________ %
Middle aged adults (45 to 64 years) _______________ %
Elderly (65 or older) _______________ %

Please make sure your totals adds up to 100 %

21. Approximately what percentage of the patients in your practice scheduled with you are... ?

White _______________ %
Black or African-American _______________ %
American Indian or Alaska Native _______________ %
Asian _______________ %
Native Hawaiian or Other Pacific Islander _______________ %
Other, please specify ____________________ _______________ %

Please make sure your totals adds up to 100 %

22. Approximately what percentage of the patients in your practice scheduled with you are of Hispanic or Latino origin?

_______________ %

23. Approximately what percentage of the patients in your practice scheduled with you are ... ?

Covered by a private insurance program that pays for some or all of their dental care?	________________ %
Covered by a public program that pays for some or all of their dental care?	________________ %
Not covered by any third party and pay their own bills?	________________ %
Not covered by any third party and receive free care or for a fee that you reduce substantially?	________________ %
	Please make sure your totals adds up to 100 %

24. Approximately what percentage of revenues or charges are derived from different payment sources? If you do not accept certain payment procedures below, please record 0% in the column.

payment source	% of practice revenue or charges from each source
dental insurance	________________ %
self-pay	________________ %
unpaid bills	________________ %
Other, please specify__________________________________	________________ %
	Please make sure your totals adds up to 100 %

25. What percentage of visits in your part of the practice are...?

Scheduled more than one day in advance	________________ %

26. What percentage of patient contact time do you (excluding your hygienist or other office staff) spend in a typical month performing the following procedures? If you always refer these procedures to other practitioners, please record 0%.

Non-implant restorative (amalgams, composites, crowns, bridges, posts, foundations, etc.)	________________ %
Implants (prosthetic and surgical procedures for implants)	________________ %
Removable Prosthetics (full and partial dentures)	________________ %

Extractions (surgical and non-surgical)	_______________ %
Periodontal therapy (surgical and non-surgical; includes scaling/root planing that you personally do)	_______________ %
Endodontic therapy (root canals and endo surgery)	_______________ %
Other (sealants, periodic & hygiene examinations, preventive dentistry, diagnostic, or other) [please specify]__________________	_______________ %

27. Please record what percentage of patient contact time you (excluding your hygienist or other office staff) spend in a typical month performing the following procedures. If you always refer these procedures to other practitioners, please record 0%.

Procedures done mainly for esthetic reasons (for example, porcelain veneers, composites and prosthodontics done mainly for esthetic reasons, in-office whitening/bleaching)	_______________ %

28. What percentage of the following procedures do you refer to other dentists?

Periodontal surgery	you refer… _______________ %	…to another dentist
Prosthetic crowns & bridges (other than implants)	you refer… _______________ %	…to another dentist
Implant surgery	you refer… _______________ %	…to another dentist
Implant restorations	you refer… _______________ %	…to another dentist
Full dentures	you refer… _______________ %	…to another dentist
Removable partial dentures	you refer… _______________ %	…to another dentist
Anterior tooth root canals	you refer… _______________ %	…to another dentist
Molar tooth root canals	you refer… _______________ %	…to another dentist
Endodontic surgery	you refer… _______________ %	…to another dentist
Non-surgical extractions	you refer… _______________ %	…to another dentist

Surgical extractions	you refer…	________________ %	…to another dentist
Orthodontics	you refer…	________________ %	…to another dentist

29. What percentage of patients do you or your staff perform the following services at some time while they are patients in your practice?

________________ % of my patients get dental X-rays
________________ % of my patients get diet counseling
________________ % of my patients get blood pressure screening
________________ % of my patients get oral cancer screening examination
________________ % of my patients get oral hygiene instruction
________________ % of my patients get in-office fluoride application
________________ % of my patients get fluoride gel/rinse prescribed or recommended for home use
________________ % of my patients get patient education from written pamphlets
________________ % of my patients get patient education from videos or slides
________________ % of my patients get intraoral photographs taken (conventional, non-video photography)
________________ % of my patients get intraoral video images taken (usually done with fiberoptic)
________________ % of my patients get in-office whitening (usually done with hydrogen peroxide)
________________ % of my patients get at-home whitening (usually done with carbamide peroxide)

30. How many root canals do you perform or refer to other dentists each month?

__________ root canals performed or referred to other dentists each month

31. How many extractions do you perform or refer to other dentists each month?

__________ extractions you perform or refer to other dentists each month

Section 5: Future Research Projects:

32. Future projects of the network will focus on topics that are important to your dental practice. We have identified 10 topic areas of most concern to dental practitioners and researchers. Please select any (all) of following 10 topic areas that are most relevant to you. In the blank text field of the selected area(s), please provide your ideas for projects.

1. General Restorative Dentistry Issues:
2. Preventive Dentistry Issues:
3. Demand for Dental Care and Access to Care Issues:
4. Business Aspects of Dental Practice and Efficiency of Practice Issues:
5. Periodontal Conditions:
6. Amalgams and Composites:
7. Safety of Dental Office:
8. Diagnostic Methods:
9. Whitening:
10. Malocclusion:
11. Other:

Thank you for participating in dental practice-based research.

Is there anything important that we overlooked? Please use the space below for any additional comments that you would like to make about your dental practice.