The National Dental Practice-Based Research Network

Dear Colleague:

We invite you to join The National Dental Practice-Based Research Network (National Dental PBRN or "network"). By completing this enrollment questionnaire, you will become part of a major effort by the National Institute of Dental and Craniofacial Research (NIDCR) to lead the nation in advancing dental practice-based research. The National Dental PBRN is a consortium of participating practices and dental organizations committed to carrying out research aimed at advancing knowledge and improving dental practice and oral health outcomes.

We are requesting that all colleagues complete this questionnaire so that current information about your practice or dental organization is on file. If you have completed the enrollment questionnaire before, you will be able to update/confirm a prepopulated questionnaire.

We estimate that completing this questionnaire will take approximately 20 minutes. After participating in this questionnaire, you may be contacted regarding participation in future research projects.

Your responses will remain confidential. Only authorized network personnel will have access to data. All information about you and your practice will be stored in a secure manner, and will not be sold, released to any insurance company, or released to any other similar interest. If you choose to participate in a network study, the data you provide in the enrollment questionnaire may be used to understand how practice and practitioner characteristics mediate the effects of interventions on study outcomes.

In addition, the National Institutes of Health provides a Certificate of Confidentiality for practitioners who participate in a study to help us keep your information confidential. This Certificate provides a way that network personnel cannot be forced to disclose information that may identify you, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings. The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of federally funded projects or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA). A Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in network research. If an insurer, employer, or other person obtains your written consent to receive research information, then the researchers may not use the Certificate to withhold that information.

Results of network studies may be published for scientific purposes, but your identity will not be revealed. Only statistical summaries will be presented. The University of Alabama at Birmingham Institutional Review Board (IRB) maintains the authority to inspect completed questionnaires to ensure compliance with IRB procedures.

If you have any additional questions, please contact Andrea Mathews, National Dental PBRN Program Manager, by email at nationaldpbrn@uab.edu or by telephone at (205) 934-2578.

If you have any questions about your rights as a network participant, or concerns or complaints about network research, you may contact the UAB Office of the IRB (OIRB) at (205) 934-3789 or toll free at 1-855- 860-3789. Regular hours for the OIRB are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday. You may also call this number in the event a network staff member cannot be reached, or you wish to talk to someone else.

With regards,

Gregg Gilbert, DDS, MBA, FAAHD, FICD
National Network Director

Enrollment Questionnaire

The National Dental Practice-Based Research Network

The nation's network

CONTACT INFORMATION

*Prefix (e.g., Dr., Ms., Miss, Mrs., Mr., Prof.)

*First Name

Middle Name (Optional)

*Last Name

Suffix (e.g., Sr., Jr)

*Degree(s) (e.g., DDS, DMD, BDSH, RDH)

*Preferred email for network communication

Alternate/Personal email

*Contact phone number

***Required information**

Please enter **your mailing address information.** This may be the same or different from your work or office address. You may include a more permanent address, such as your home address.

❑ USA ❑ International

Mailing address line 1

Mailing address line 2

City/Province/Region State

Zip code Country

Which of the following best describes your primary occupation?

Dentist practicing within the US

- ❑ In solo private practice
- ❑ In private practice, 2-4 dentists total
- ❑ In private practice, 5 or more dentists total
- ❑ Managed care or preferred provider organization
- ❑ Dental school, academic dental institution or facility staffed by the dental school
- ❑ Corporate Dentistry
- ❑ Armed Forces
- ❑ Federal government facility (e.g. VA, Public Health Service, etc.)
- ❑ Public health practice, community health center, or publicly funded clinic (but not a federal facility)
- ❑ Hospital

Dental Practice Staff

- ❑ Dental Hygienist
- ❑ Dental Therapist

Student

- ❑ Dental Student
- ❑ Graduate Student/Intern/Resident
- ❑ Dental Hygiene Student
- ❑ Dental Therapy Student

Other Dental Occupations

- ❑ Dental Assistant
- ❑ Receptionist or other office staff
- ❑ Dentist practicing *only* outside of the US
- ❑ No longer practicing dentistry (e.g., retired, teach, research)
- ❑ Occupation unrelated to dentistry
- ❑ Other

If you are a practicing US dentist, dental hygienist, dental therapist, or student please answer question 2. All others, please skip to question 3.

2. What year did you or do you expect to graduate from dental school, a dental hygiene program, or a dental therapist program? ☐☐☐☐ (YYYY)

DEMOGRAPHIC INFORMATION

Note: Demographic information is collected to allow comparison to other surveys, studies, and census data.

3. What is your sex/gender?

- ❑ Male
- ❑ Female
- ❑ Other

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4. What is your year of birth? ☐☐☐☐ (YYYY)

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5. Are you of Hispanic or Latino origin?

- ❑ Yes
- ❑ No

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6. What racial categories best describe you? (check all that apply)

- ❑ White or Caucasian
- ❑ Black or African-American
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Asian Indian/East Indian
- ❑ Middle Eastern
- ❑ Other

Dentists, dental hygienists and dental therapists please continue.
All others: Thank you, you have completed the Enrollment Questionnaire.

MEMBERSHIP PARTICIPATION

7. Individual members of the network participate at various levels. Please indicate below your desired level of participation. Note: Individuals participating at the limited or full levels participate only in those studies of interest to them. Level of participation may be changed at any time by contacting a Node Coordinator.

- ❑ **Full participation:** Receive newsletters/correspondence **AND** participate in surveys/questionnaires **AND** participate with in-office research
- ❑ **Limited participation:** Receive newsletters/correspondence **AND** participate in surveys/questionnaires
- ❑ **Informational:** Receive newsletter/correspondence **ONLY**

DENTAL PRACTICE INFORMATION

8. At how many different locations do you see patients?

- ❑ One location (*complete 9A. Primary Site*)
- ❑ Two or more locations (*complete both 9A & 9B*)

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9. A. Primary Site

Name of Practice/Institution

❑ Check here if the same as mailing address

Physical/office address line 1

Physical/office address line 2

City | State | Zip code

Office phone number | Alternative phone number

Cell phone number | Fax number

Website address (if applicable)

B. Secondary Site

Name of Practice/Institution

Physical/office address line 1

Physical/office address line 2

City | State | Zip code

Office phone number

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

- ❑ Full-time (32 or more hours per week)
- ❑ Part-time (less than 32 hours per week)

For the following questions, if you practice at more than one site, answer for the **PRIMARY SITE ONLY**

11. Please indicate the approximate percentage of patients in your practice who are:

- ____ % Children and teenagers (1-18 years)
- ____ % Young adults (19-44 years)
- ____ % Middle aged adults (45 to 64 years)
- ____ % Older adults (65 or older)
- ____ Total (please make sure your total adds up to 100%)

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12. Please indicate the approximate percentage of patients in your practice who are of Hispanic or Latino ethnicity: [ ] %

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13. Please indicate the approximate percentage of patients in your practice whose primary race is:

[ ] % White or Caucasian
[ ] % Black or African-American
[ ] % American Indian or Alaska Native
[ ] % Asian
[ ] % Native Hawaiian or Other Pacific Islander
[ ] % Other
[ ] Total (please make sure your total adds up to 100%)

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14. Please indicate the approximate percentage of patient in your practice who are (indicate primary coverage):

[ ] % Covered by a private insurance program that pays for part/all of their dental care
[ ] % Covered by a public program that pays for part/all of their dental care
[ ] % Not covered by any third party and pays out of pocket for dental care
[ ] % Receiving free care or substantially reduced fees courtesy of this practice
[ ] Total (please make sure your total adds up to 100%)

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15. In my practice setting we have:

❑ Internet access, but not Wi-Fi
❑ Wi-Fi (wireless) internet
❑ We do not have internet in the practice

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16. Do you use digital radiography as part of routine patient care?

❑ Yes
❑ No

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17. What brand of electronic patient records software do you use?

❑ I do not use electronic patient record software
❑ Axium
❑ Dentrix
❑ Dolphin
❑ Eagle Dental
❑ Eagle Soft
❑ Easy Dental
❑ EPIC/EPIC Wisdom
❑ GDS Works
❑ Improvis
❑ MacPractice
❑ Open Dental
❑ Ortho2
❑ PBS Endo
❑ Practice Works
❑ QSI/QDW/Nextgen/CPS
❑ Soft Dent
❑ TOPS
❑ Other

Dental hygienists and dental therapists: Thank you! You have now completed the Enrollment Questionnaire.

DENTAL EXPERIENCE

18. Do you consider yourself a general practitioner or a specialist?

- ❑ General practitioner
- ❑ Specialist

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19. Have you completed any type of formal training, degree or certificate programs after dental school? (check ALL items that apply)

- ❑ None
- ❑ Advanced Education in General Dentistry program (AEGD) 12 months
- ❑ Advanced Education in General Dentistry program (AEGD) 24 months
- ❑ Fellow of the Academy of General Dentistry (FAGD)
- ❑ Mastership in the Academy of General Dentistry (MAGD)
- ❑ Clinical Fellowship in Craniofacial and Special Care Orthodontics
- ❑ Dental Anesthesiology
- ❑ Dental Public Health
- ❑ Endodontics
- ❑ General Practice Residency (GPR) 12 months
- ❑ General Practice Residency (GPR) 24 months
- ❑ Oral and Maxillofacial Pathology
- ❑ Oral and Maxillofacial Radiology
- ❑ Oral and Maxillofacial Surgery
- ❑ Oral and Maxillofacial Surgery Clinical Fellowships Cosmetic
- ❑ Oral and Maxillofacial Surgery Clinical Fellowships Craniofacial
- ❑ Oral and Maxillofacial Surgery Clinical Fellowships Oncology
- ❑ Oral Medicine
- ❑ Orofacial Pain or TMD
- ❑ Orthodontics & Dentofacial Orthopedics
- ❑ Orthodontics/Periodontics
- ❑ Pediatric Dentistry
- ❑ Periodontics
- ❑ Prosthodontics
- ❑ Prosthodontics/Maxillofacial Prosthetics
- ❑ Other formal training (e.g., non-CODA approved):

Enter program focus

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

- ❑ American Dental Association
- ❑ Academy of General Dentistry
- ❑ American Association of Endodontists
- ❑ American Academy of Oral & Maxillofacial Pathology
- ❑ American Academy of Oral & Maxillofacial Radiology
- ❑ American Association of Oral and Maxillofacial Surgeons
- ❑ American Association of Orthodontists
- ❑ American Academy of Pediatric Dentistry
- ❑ American Academy of Periodontology
- ❑ American College of Prosthodontists
- ❑ American Society of Dentist Anesthesiologists
- ❑ American Academy of Orofacial Pain
- ❑ American Academy of Oral Medicine

Note: If you practice at more than one location, please include all locations when answering the following question.

21. Please indicate the frequency with which **YOU PERSONALLY** perform the following procedures in a typical month. Only considering patients who need such a procedure, please answer "routinely" **if you would personally** do the applicable procedure on 50% or more of these patients; "occasionally" if you would do the procedure on at least some of these patients, but less than 50% of them; "not at all" if you would never do the procedure but instead refer the procedure.

	Not at all	Occasionally	Routinely
Non-implant restorative (amalgams, composites, crowns, veneers, bridges, posts, foundations, etc.)	❑	❑	❑
Implants (prosthetic/restorative procedures only)	❑	❑	❑
Implants (surgical procedures only)	❑	❑	❑
Removable prosthetics (full and partial dentures)	❑	❑	❑
Extractions (surgical and non-surgical)	❑	❑	❑
Periodontal therapy (non-surgical only; includes scaling/root planing)	❑	❑	❑
Periodontal therapy (surgical)	❑	❑	❑
Endodontic therapy (anteriors/premolars only)	❑	❑	❑
Endodontic therapy (molars only)	❑	❑	❑
Procedures for esthetic reasons only (composites, crowns, veneers, etc.)	❑	❑	❑
Cleft/Craniofacial care	❑	❑	❑
Orthodontic treatment	❑	❑	❑

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22. 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

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23. Where/how did you hear about the network? (check all that apply)

- ❑ An email from the National Dental PBRN
- ❑ Printed information in the mail
- ❑ Referred by another practitioner, friend or employer
- ❑ Dental society publication or email
- ❑ Conference presentation or booth
- ❑ Read about it in a journal article
- ❑ NIDCR webpage or Research Funding Announcement
- ❑ I do not recall

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24. Have we left out anything important to your practice? Please use the space below for any additional comments.

MEMBER DIRECTORY

DENTISTS PRACTICING IN THE US: The Network has established a Member Directory as a resource for our practitioners. This is **only** available to network members, and contains data such as name, email address and region. Your information **will be included** unless you opt out.

❑ I prefer to **opt out** of the member directory.

Thank you! You have now completed the enrollment questionnaire.