The National Dental Practice-Based Research Network

Welcome to the National Dental PBRN Enrollment Questionnaire

Please enter your email address and last name below and click the "Submit".

Email Address:

Last Name:

Submit

If you have any questions before completing the online questionnaire, please email us for help at dentalpbrn@uab.edu.

Dear Colleague:

As 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, we invite you to complete this questionnaire to help establish The National Dental Practice-Based Research Network (National Dental PBRN). This consortium of participating practices and dental organizations is committed to advancing knowledge and improving dental practice.

We are requesting that all colleagues, including those who may have previously participated in a dental practice-based research network (such as Dental PBRN, NW PRECEDENT, or PEARL), complete this new questionnaire so that current information about your practice or dental organization is on file. **We estimate that completing this survey will take approximately 30 minutes. After participating in this questionnaire, you may be contacted regarding future research projects.**

Your participation and responses will remain confidential. Only authorized study personnel will have access to data. All information, both electronic and paper, will be stored in a secure manner. **Your information will not be sold, used for any reason other than research, released to any insurance company, or released to any other similar interest.**

Results 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 questions about your rights as a research participant, you may contact Mr. Jonathan Miller, Director of the IRB at (205) 934-3789 or (800) 822-8816. Press option #1 for the operator and request extension 4-3789 (M-F, 8:00 AM - 5:00 PM Central Time).

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

With regards,

Gregg Gilbert, DDS, MBA, FAAHD, FICD
National Network Director
The National Dental Practice-Based Research Network

Continue

Questionnaire Instructions

The following instructions will help you complete this questionnaire.

- Most multiple choice questions only allow for one answer. Click on the button next to your "best" answer or enter your response.
  - If you need to change your answer, click on your new answer and your response will change, or re-type your response.
  - To totally delete your answers to a question, double click on the answer or highlight and delete your answer.
- Some questions will allow multiple answers, and are noted by "Check All That Apply."
- Use the "Continue" and "Previous Page" buttons to move forward and backward throughout the survey.
- **DO NOT use the forward and back arrows at the top left corner of your internet browser screen.**
- On occasion, if you forget to answer a question or provide an answer that is inconsistent, you may see a message highlighted in yellow that provides information on how to fix the problem. If you prefer to skip the question, click on the "Continue" button.
- Press the "Save and Continue Later" button if you wish to save your answers and complete the survey at a later time. You can come back to the survey by returning to https://www.ndpbrn-research.org/Enrollment/ and re-entering the same email address and last name you used when starting the survey. You will automatically return to the last screen you were on.
- The survey will "time out" after 15 minutes of no activity. Follow the instructions on how to get back into the survey. The next time you log in, you will be returned to the last screen you were on.

Previous Page | Continue

1. If you are a DENTIST and currently practicing, answer the following questions: name/degree(s)/email, A, B, C1/D1 (and C2/D2, C3/D3, if applicable), and 1-31.
2. If you are a DENTAL HYGIENIST/THERAPIST and currently practicing, answer the following questions: name/degree(s)/email, A, B, C1/D1 (and C2/D2, C3/D3, if applicable), 1-22, and 32-37.
3. If you are NOT CURRENTLY PRACTICING (for example, student, educator, clinical researcher, retired, awaiting licensing in the U.S., between jobs, etc.), answer the following questions: name/degree(s)/email, A, Preferred Mailing Address and Phone Numbers, 1-4, 19-21, and 38.

Previous Page Continue

Enrollment Form

Prefix: (e.g., Dr., Mr., Ms.)

First Name:

Middle Name:

Last Name:

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

Degree(s):
(e.g., DDS, DMD, BSDH, RDH)

Preferred Email:

Additional Email:

A. Are you currently licensed to treat patients and actually treat patients on a recurring basis?

- Yes
- No (for example, student, retired, awaiting licensing in the U.S., between jobs, etc.)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

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

- One location
- Two locations
- Three locations
- More than 3 locations

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

Site 1

C1. Name of Practice:

Address line 1:

Address line 2:

City:

State:

Zip code:

Office phone number: - -

Alternative phone number: - -

Fax number: - -

Website address (if applicable):

D1. Please check all the types of dentists who practice at this location.

- Endodontist
- General Practitioner
- Oral/Maxillofacial Surgeon
- Orthodontist
- Pediatric Dentist
- Periodontist
- Prosthodontist
- Other (please specify below)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

Site 2

C2. Name of Practice:

Address line 1:

Address line 2:

City:

State:

Zip code:

Office phone number: - -

Alternative phone number: - -

Fax number: - -

Website address (if applicable):

D2. Please check all the types of dentists who practice at this location.

- Endodontist
- General Practitioner
- Oral/Maxillofacial Surgeon
- Orthodontist
- Pediatric Dentist
- Periodontist
- Prosthodontist
- Other (please specify below)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

Site 3

C3. Name of Practice:

Address line 1:

Address line 2:

City:

State:

Zip code:

Office phone number: - -

Alternative phone number: - -

Fax number: - -

Website address (if applicable):

D3. Please check all the types of dentists who practice at this location.

- Endodontist
- General Practitioner
- Oral/Maxillofacial Surgeon
- Orthodontist
- Pediatric Dentist
- Periodontist
- Prosthodontist
- Other (please specify below)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

Preferred Mailing Address and Phone Numbers

Address line 1:

Address line 2:

City:

State:

Zip code:

Primary phone number: - -

Alternative phone number: - -

Fax number: - -

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

1. What is your gender?

- Male
- Female

2. What is your year of birth?

3. Are you of Hispanic or Latino origin?

- Yes
- No

4. What is your racial identification?

- White or Caucasian
- Black or African-American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Other (please specify below)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

5. Do you consider your primary practice location to be:

- Inner city of urban area
- Urban (not inner city)
- Suburban
- Rural

6. 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)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

FOR QUESTIONS **7 - 17:** IF YOU PRACTICE AT MORE THAN ONE SITE, ANSWER FOR THE **MAIN SITE ONLY**

7. Please indicate, on average, how long a patient in your practice has to wait:

For a new patient exam appointment		days
For a treatment procedure appointment		days
In the waiting room after arriving for an appointment		minutes

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

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

Please make sure your total adds up to 100%

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

9. Please indicate the approximate percentage of patients in your practice who are of Hispanic or Latino ethnicity.

_____ %

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

White or Caucasian	_____ %
Black or African-American	_____ %
American Indian or Alaska Native	_____ %
Asian	_____ %
Native Hawaiian or Other Pacific Islander	_____ %
Other, please specify **race** below	_____ %
	_____

Please make sure your total adds up to 100%

_____

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

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

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	%

Please make sure your total adds up to 100%

12. Please estimate the following for your patient population:

Patients who come for **one visit only**	%
Patients who come **occasionally, only** when they have an emergency or specific problem/concern	%
Patients who come **irregularly** whether or not they have a problem/concern	%
Patients who come **regularly** as recommended whether or not they have a problem/concern	%

Please make sure your total adds up to 100%

Previous Page Continue

Save and Continue Later

Questionnaire Instructions

Previous Page Continue

13. In my practice setting, we have (check all that apply):

- ☐ Internet access for administrative staff
- ☐ Internet access in the operatories (chairside)
- ☐ Internet access for clinical staff outside the operatories (e.g., break-room, dentist's office)
- ☐ Wi-Fi (wireless) internet
- ☐ We do not have internet in the practice

14. Do you use electronic patient records to manage clinical/patient care data (as opposed to billing/scheduling)?

- ○ Yes (If yes, answer Question 15)
- ○ No (If no, answer Question 16)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

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

- Dentrix
- Soft Dent
- Eagle Soft
- Eagle Dental
- Practice Works
- GSD Works
- Axium
- Other, please specify below

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Skip to Question 17.

Previous Page Continue

16. Within the next two years, how likely are you to begin using electronic patient records to manage clinical patient data?

- Very likely
- Somewhat likely
- Not likely
- Not sure at this time

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

17. Please indicate how you store clinical information. If you store information on both paper and computer, please check <u>both</u> categories.

Type of Information	Paper	Computer
medical history	☐	☐
dental history	☐	☐
progress notes	☐	☐
completed treatment	☐	☐
radiographs	☐	☐
other images or photographs	☐	☐
appointments	☐	☐

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

18. Individual members of the network participate at various levels. Please indicate below your desired level of participation.

- **Informational**: receive newsletters/correspondence **only**
- **Limited participation**: receive newsletters/correspondence AND participate in surveys/questionnaires
- **Full participation**: receive newsletters/correspondence AND participate in surveys/questionnaires AND participate with in-office research

19. When receiving a notice of new network results and information (e.g., study findings, notice of publications, newsletters), how do you prefer to receive this information?

- By e-mail
- Printed, sent by postal mail

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

20. 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, dental hygienists, and researchers. Please select any/all of the 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. Occlusion:
- [ ] 10. Systemic Health Issues related to Oral Health:
- [ ] 11. Other:

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

21. During the period 2005-2012, were you a member of any of these dental practice-based research networks?

- The Dental PBRN, administratively based at UAB
- NW PRECEDENT, based at University of Washington and OHSU
- PEARL, based at NYU
- None of these
- Not sure

22. Are you a dentist or a dental hygienist/dental therapist?

- Dentist
- Dental hygienist/dental therapist (this will take you to Question #32)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

23. Which one category best describes your main or primary dental practice?

- **Owner** of a private practice
- **Associate or employee** of a private practice
- HealthPartners Dental Group
- Permanente Dental Associates
- Other managed care or preferred provider organization
- Public health practice, community health center, or publicly-funded clinic (but not a federal facility)
- Federal government facility (e.g., VA, Department of Defense, Public Health Service)
- Dental school, academic dental institution, or facility staffed by the dental school

Previous Page Continue Save and Continue Later

Questionnaire Instructions

If you are the owner of a private practice or associate or employee of a private practice, provide the total number of dentists in the practice including yourself: _____

Previous Page Continue

24. What year did you graduate from dental school?

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

25. Did you graduate from a dental school in the United States, Canada, or some other country?

- United States
- Canada
- Other

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Provide the name of the United States, Canadian, or other dental school you attended:

_____

Previous Page Continue

26. Are you a general practitioner or a specialist?

- General practitioner (If General practitioner selected, answer Question 26a)
- Specialist (If Specialist selected, answer Question 26b)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

26a. Please check which item or items apply to you:

- [ ] I have not completed any type of formal advanced training program after dental school
- [ ] I completed an Advanced Education in General Dentistry (AEGD) program
- [ ] I completed a General Practice Residency (GPR) program
- [ ] I am a Fellow of the Academy of General Dentistry (FAGD)
- [ ] I completed Mastership in the Academy of General Dentistry (MAGD)
- [ ] I completed some other advanced training program (please specify below)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

26b. Please check all specialty training

- ☐ Endodontist Year: _____
- ☐ Pediatric Dentist Year: _____
- ☐ Periodontist Year: _____
- ☐ Prosthodontist Year: _____
- ☐ Oral/Maxillofacial Surgeon Year: _____
- ☐ Orthodontist Year: _____
- ☐ Other (please specify below) Year: _____

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

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

- [ ] American Dental Association/state dental association/local association
- [ ] Academy of General Dentistry/state academy of general dentistry
- [ ] Other (please specify)
- [ ] Other (please specify)
- [ ] Other (please specify)
- [ ] Other (please specify)
- [ ] Other (please specify)
- [ ] None

Please specify:

Please specify:

Please specify:

Please specify:

Please specify:

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

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

28. How many patients do YOU personally treat during a typical work week? (Do NOT include patients seen by a hygienist even if you see the patient for a routine 'recall' examination)

_____ patient visits in a typical week

29. Please indicate the frequency with which YOU personally perform the following procedures in a typical month. If you always refer these procedures to other practitioners, please record not at all. (This may include examinations on patients scheduled with a dental hygienist/dental therapist.)

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

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

30. Would you be willing to use data from your computer system for network studies, where feasible and allowed by confidentiality regulations, instead of having to enter them separately by hand or sending them to your regional data center?

- Yes
- Maybe, it depends on the study
- No
- I do not have a computer system at this time

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

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

32. Please indicate the educational setting for your dental hygiene/dental therapist training.

- Technical or community college
- Four-year college
- Alabama Dental Hygiene Program (ADHP)
- Other (please specify below)

33. What year did you initially become licensed as a dental hygienist/dental therapist?

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

34. What is the highest degree you have obtained?

- Certificate
- Associate
- Baccalaureate
- Master's
- PhD
- Other (please specify below)

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

- American Dental Hygienists Association
- State Dental Hygienists Association
- Study clubs
- Other (please specify below)
- None

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

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

36. In a typical month, for what percentage of patients do YOU personally perform the following procedures? If you do not perform these procedures, please record 0%.

Prophylaxis (i.e., "cleanings" and assessments)	% of patients
Periodontal therapy/scaling/root planing/periodontal maintenance	% of patients
Subgingival antimicrobial placement	% of patients
Restorative functions	% of patients
Local anesthesia (injection)	% of patients
Local anesthesia (subgingival with a gel)	% of patients
Dental sealants	% of patients
Dentinal desensitizers	% of patients
Radiographs	% of patients
Patient education (in-office)	% of patients
Tobacco cessation counseling	% of patients
Dietary counseling	% of patients
Other (please specify below)	% of patients

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

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

38. Which category best describes you?

- Dentist - Student
- Dentist - Retired
- Dentist - Awaiting U.S. license
- Dentist - Between positions

- Dental Hygienist/Therapist - Student
- Dental Hygienist/Therapist - Retired
- Dental Hygienist/Therapist - Awaiting U.S. license
- Dental Hygienist/Therapist - Between positions

- Dental Assistant
- Office Manager/Administrator
- Educator
- Clinical researcher
- Other (please specify below)

Previous Page Continue Save and Continue Later

Questionnaire Instructions

If you are satisfied that you are finished with the questionnaire, please click the Submit Survey button below. Once you have clicked on this button, your questionnaire is considered complete, and you will not be able to change your responses.

Return to Survey | **Submit Survey**

The National Dental Practice-Based Research Network

Thank you for participating in dental practice-based research!

If you have any questions or would like us to contact you, please email us at dentalpbrn@uab.edu.

Exit

From: National Dental
Sent: Monday, September 24, 2012 12:59 PM
To:
Subject: National Dental PBRN Enrollment Questionnaire – Confirmation of Receipt

Dear Colleague,

Thank you for completing the Enrollment Questionnaire for the National Dental Practice-Based Research Network (National Dental PBRN). We have received your questionnaire and you are now enrolled in the National Dental PBRN. The Regional Coordinator for your area will be contacting you in the near future to follow up with you about participating in the National Dental PBRN.

If you feel any of your colleagues may also be interested in joining the National Dental PBRN, please forward this email and invite them to join by visiting http://www.nationaldentalpbrn.org/, and then clicking on the link to enrollment.

Again, thank you for your interest and participation in *the nation's network*.

Gregg Gilbert, DDS, MBA, FAAHD, FICD
National Network Director
The National Dental Practice-Based Research Network