The National Dental Practice-Based Research Network

# ALL IDENTIFYING INFORMATION HAS BEEN OMITTED FROM POSTED DATA

National Dental PBRN Enrollment Questionnaire

**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.**
- For survey questions that require percentages (questions 8, 9, 10, 11, 12, 36), whole numbers (e.g. 10) or numbers with one decimal point (e.g. 10.1) can be entered.
- 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/DENTAL THERAPIST/LICENSED ASSISTANT 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 Address and Phone Numbers (Name of Institution, if applicable), 1-4, 19-21, and 38.
4. If you are an OFFICE SUPPORT STAFF (for example, dental assistant, office manager/administrator or other office staff) answer the following questions: name/degree(s)/email, A, B, C1/D1 (and C2/D2, C3/D3, if applicable), 1-4, and 19-21.
5. If you are currently practicing outside of the U.S. (INTERNATIONAL), answer the following questions: name/degree(s)/email, A, Preferred Address and Phone Numbers (Name of Practice/Institution, if applicable), C1/D1 (and C2/D2, C3/D3, if applicable), 1-4, and 19-21.

Previous Page  Continue

## Enrollment Form

**Prefix:** TITLE

**First Name:** FIRSTNAME

**Middle Name:** MIDDLENAME

**Last Name:** LASTNAME

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

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

**Preferred Email for National Dental PBRN communication:** PREFERREDEMAILADDRESS

**Additional Email:** ALTERNATEEMAIL

**A. Are you currently licensed in the U.S. to treat patients, and do you actually treat patients in the U.S. on a recurring basis?**

- Yes
- No • office support staff (dental assistant, office manager/administrator or other office staff)
- No • student, retired, awaiting licensing in the U.S., between jobs, educator, researcher, or other
- No • Non•U.S. practitioner

NOTE: QA & Q22 are combined into one field: SAMPLETYPEID (numeric) and SAMPLETYPENAME (character)
1-Dentist
2-Hygienist
3-Non-Practicing
4-Office Staff

Previous Page  Continue  Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

**B. At how many locations do you see patients?** PRACTICELOCATIONS

1 One location
2 Two locations
3 Three locations
4 More than 3 locations

Previous Page Continue Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

**Site 1**

**C1. Name of Practice/Institution:** PRACTICENAME

**Physical/Office Address line 1:** STREET1

**Physical/Office Address line 2:** STREET2

**City:** CITY

**State:** STATE

**Zip code:** ZIP

☐ **Check if your mailing address is different than your physical/office address above.**

**Office phone number:** ___ • ___ • ___ PHONE1

**Alternative phone number:** ___ • ___ • ___ PHONE2

**Fax number:** ___ • ___ • ___ FAX

**Website address (if applicable):** ___ URL

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

- ☐ Endodontist ENDODONTIST
- ☐ General Practitioner GENERALPRACTITIONER
- ☐ Oral/Maxillofacial Surgeon ORAL_MAXILLOFACIALSURGEON
- ☐ Orthodontist ORTHODONTIST
- ☐ Pediatric Dentist PEDIATRICDENTIST
- ☐ Periodontist PERIODONTIST
- ☐ Prosthodontist PROSTHODONTIST
- ☐ Other (please specify below) OTHER

OTHERTYPE

Previous Page Continue Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

**Site 2**

**C2. Name of Practice/Institution:** C2SITE2_PRACTICENAME

**Physical/Office Address line 1:** C2SITE2_ADDRESS1

**Physical/Office Address line 2:** C2SITE2_ADDRESS2

**City:** C2SITE2_CITY

**State:** C2SITE2_STATE

**Zip code:** C2SITE2_ZIPCODE

**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 D2SITE2_TYPE1
- ☐ General Practitioner D2SITE2_TYPE2
- ☐ Oral/Maxillofacial Surgeon D2SITE2_TYPE3
- ☐ Orthodontist D2SITE2_TYPE4
- ☐ Pediatric Dentist D2SITE2_TYPE5
- ☐ Periodontist D2SITE2_TYPE6
- ☐ Prosthodontist D2SITE2_TYPE7
- ☐ Other (please specify below) D2SITE2_TYPE8

D2SITE2_TYPE8OTHER

Previous Page Continue Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

**Site 3**

**C3. Name of Practice/Institution:** C3SITE3_PRACTICENAME

**Physical/Office Address line 1:** C3SITE3_ADDRESS1

**Physical/Office Address line 2:** C3SITE3_ADDRESS2

**City:** C3SITE3_CITY

**State:** C3SITE3_STATE

**Zip code:** C3SITE3_ZIPCODE

**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 D3SITE3_TYPE1
- ☐ General Practitioner D3SITE3_TYPE2
- ☐ Oral/Maxillofacial Surgeon D3SITE3_TYPE3
- ☐ Orthodontist D3SITE3_TYPE4
- ☐ Pediatric Dentist D3SITE3_TYPE5
- ☐ Periodontist D3SITE3_TYPE6
- ☐ Prosthodontist D3SITE3_TYPE7
- ☐ Other (please specify below) D3SITE3_TYPE8

D3SITE3_TYPE8OTHER

Previous Page Continue Save and Continue Later

**Questionnaire Instructions**

Previous Page  Continue

**Preferred Address and Phone Numbers**

| | |
|---|---|
| **Name of Institution (if applicable):** | MAILINGPRACTICENAME |
| **Address line 1:** | MAILINGSTREET1 |
| **Address line 2:** | MAILINGSTREET2 |
| **City:** | MAILINGCITY |
| **State:** | MAILINGSTATE |
| **Zip code:** | MAILINGZIP |

☐ **Check if your mailing address is different than your preferred address above.**

**Primary phone number:** ___ • ___ • ____

**Alternative phone number:** ___ • ___ • ____

**Fax number:** ___ • ___ • ____

Previous Page  Continue  Save and Continue Later

**Questionnaire Instructions**

Previous Page  Continue

## Preferred Address and Phone Numbers

| | |
|---|---|
| **Name of Practice/Institution (if applicable):** | |
| **Address line 1:** | |
| **Address line 2:** | |
| **City:** | |
| **State:** | |
| **Zip/mail code:** | |
| **Country:** | COUNTRY |
| **Primary phone number:** | |

Previous Page  Continue  Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

**1. What is your gender?** GENDER

1 ○ Male
2 ○ Female

**2. What is your year of birth?** YEAROFBIRTH

**3. Are you of Hispanic or Latino origin?** HISPANIC

1 ○ Yes
2 ○ No

**4. What is your racial identification?** RACE

1 ○ White or Caucasian
2 ○ Black or African•American
3 ○ American Indian or Alaska Native
4 ○ Asian
5 ○ Native Hawaiian or Other Pacific Islander
6 ○ Other (please specify below) RACEOTHER

Previous Page Continue Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

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

1 ○ Inner city of urban area
2 ○ Urban (not inner city)
3 ○ Suburban
4 ○ Rural

**6. Do you practice full•time or part•time (including all sites at which you practice)?** FULLTIMEPARTTIME

1 ○ Full•time (32 or more hours per week)
2 ○ 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 **PATIENTWAIT_NEWPATIENTAPPT** |
| For a treatment procedure appointment | | days **PATIENTWAIT_TREATMENTAPPT** |
| In the waiting room after arriving for an appointment | | minutes **PATIENTWAIT_INWAITINGROOM** |

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

| | | |
|---|---|---|
| Children & Teenagers (1 to 18 years) | | % **PERCENTAGE_1_18** |
| Young adults (19 to 44 years) | | % **PERCENTAGE_19_44** |
| Middle aged adults (45 to 64 years) | | % **PERCENTAGE_45_64** |
| Older Adults (65 or older) | | % **PERCENTAGE_65_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.**

% PERCENTRACE_HISPANIC

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

| | |
|---|---|
| White or Caucasian | %PERCENTRACE_WHITE |
| Black or African•American | %PERCENTRACE_BLACK |
| American Indian or Alaska Native | %PERCENTRACE_AMERICANINDIAN |
| Asian | %PERCENTRACE_ASIAN |
| Native Hawaiian or Other Pacific Islander | %PERCENTRACE_HAWAIIANPACIFICISL |
| Other, please specify **race** below | %PERCENTRACE_OTHER |
| | PERCENTRACE_OTHERTYPE |

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 _____ %
PERCENTINSURANCE_PRIVATE
Covered by a public program that pays for part/all of their dental care _____ %
PERCENTINSURANCE_PUBLIC
Not covered by any third party and pays out of pocket for dental care _____ %
PERCENTINSURANCE_NONE
Receiving free care or substantially reduced fees courtesy of this practice _____ %
PERCENTINSURANCE_REDUCEDFEE

_____

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** _____ %
PERCENTVISIT_ONLYONCE

Patients who come **occasionally, only** when they have an emergency or specific problem/concern _____ %
PERCENTVISIT_EMERGENCYONLY

Patients who come **irregularly** whether or not they have a problem/concern _____ %
PERCENTVISIT_IRREGULARLY

Patients who come **regularly** as recommended whether or not they have a problem/concern _____ %
PERCENTVISIT_REGULARLY

_____

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

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

1 ○ Yes (If yes, answer Question 15) ELECTRONICPATIENTRECORDS

2 ○ 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?** PATIENTRECORDSSOFTWAREID

1 Dentrix
2 Soft Dent
3 Eagle Soft
4 Eagle Dental
5 Practice Works
6 GSD Works
7 Axium
8 Other, please specify below

PATIENTRECORDSSOFTWARE_OTHER

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?** LIKELYTOUSEELECPATIENTRECORDS

1 ○ Very likely
2 ○ Somewhat likely
3 ○ Not likely
4 ○ 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 | ☐ PAPER_MEDICALHISTORY | ☐ ELEC_MEDICALHISTORY |
| dental history | ☐ PAPER_DENTALHISOTRY | ☐ ELEC_DENTALHISOTRY |
| progress notes | ☐ PAPER_PROGRESSNOTES | ☐ ELEC_PROGRESSNOTES |
| completed treatment | ☐ PAPER_TREATMENT | ☐ ELEC_TREATMENT |
| radiographs | ☐ PAPER_RADIOGRAPHS | ☐ ELEC_RADIOGRAPHS |
| other images or photographs | ☐ PAPER_IMAGES | ☐ ELEC_IMAGES |
| appointments | ☐ PAPER_APPOINTMENTS | ☐ ELEC_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.** PARTICIPATIONLEVEL

1 ○ **Informational**: receive newsletters/correspondence **only**

2 ○ **Limited participation**: receive newsletters/correspondence AND participate in surveys/questionnaires

3 ○ **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?** PREFERREDCONTACTMETHOD

1 ○ By e•mail

2 ○ Printed, sent by postal mail

Previous Page Continue Save and Continue Later

**Questionnaire Instructions**

Previous Page | Continue

**20. Future network studies will focus on topics that are important to a dental practice. We have identified 10 areas that seem to be of most concern. Please select any of the following 10 areas on the next several screens that are most relevant to you.**

**In the blank text field of the selected area(s), please state what research question you would like the network to answer. Please be as specific as possible. For example, state what clinical question you want answered, what clinical outcome would be measured, what the intervention and control groups or comparison groups would be, how the data might be collected, etc.**

☐ 1. General Restorative Dentistry Issues: TOPICGENERALRESTORATIVE

TOPICGENERALRESTORATIVE_IDEAS

☐ 2. Preventive Dentistry Issues: TOPICPREVENTIVE

TOPICPREVENTIVE_IDEAS

☐ 3. Demand for Dental Care and Access to Care Issues: TOPICACCESSTOCARE

TOPICACCESSTOCARE_IDEAS

☐ 4. Business Aspects of Dental Practice and Efficiency of Practice Issues: TOPICBUSINESS

TOPICBUSINESS_IDEAS

☐ 5. Periodontal Conditions: TOPICPERIODONTAL

TOPICPERIODONTAL_IDEAS

☐ 6. Amalgams and Composites: TOPICAMALGAMS

TOPICAMALGAMS_TYPE

☐ 7. Safety of Dental Office: TOPICSAFETYOFOFFICE

TOPICSAFETYOFOFFICE_IDEAS

☐ 8. Diagnostic Methods: TOPICDIAGNOSTIC

TOPICDIAGNOSTIC_IDEAS

☐ 9. Occlusion: TOPICOCCLUSION

TOPICOCCLUSION_IDEAS

☐ 10. Systemic Health Issues related to Oral Health: TOPICSYSTEMICHEALTH

TOPICSYSTEMICHEALTH_IDEAS

☐ 11. Other: TOPICOTHER

TOPICOTHER_IDEAS

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?** PREVIOUSNETWORKMEMBERSHIP

1 ◯ The Dental PBRN, administratively based at UAB

2 ◯ NW PRECEDENT, based at University of Washington and OHSU

3 ◯ PEARL, based at NYU

4 ◯ None of these

5 ◯ Not sure

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

◯ Dentist

◯ Dental hygienist/dental therapist/licensed assistant (this will take you to Question #22a and then #32) See annotation for QA, page 5

Previous Page Continue Save and Continue Later

Questionnaire Instructions

Previous Page Continue

**22a. Please select your type:**

HYGIENISTOTHER_TYPE

- ◯ Dental hygienist
- ◯ Dental therapist
- ◯ Licensed assistant

Previous Page Continue Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

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

1 ○ **Owner** of a private practice
2 ○ **Associate or employee** of a private practice
3 ○ HealthPartners Dental Group
4 ○ Permanente Dental Associates
5 ○ Other managed care or preferred provider organization
6 ○ Public health practice, community health center, or publicly•funded clinic (but not a federal facility)
7 ○ Federal government facility (e.g., VA, Department of Defense, Public Health Service)
8 ○ 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: _____

TOTALDENTISTS

Previous Page  Continue

**24. What year did you graduate from dental school?**

DENTALSCHOOLYEAR

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?** DENTALSCHOOLCOUNTRY Q25

- 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:

_____

Q25_USA Q25_CAN
Q25_USAOTHER Q25_CANOTHER Q25_OTHER

Previous Page Continue

**26. Are you a general practitioner or a specialist?** SPECIALIST

1 ○ General practitioner (If General practitioner selected, answer Question 26a)

2 ○ 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 TRAININGGEN_NONE
- ☐ I completed an Advanced Education in General Dentistry (AEGD) program TRAININGGEN_AEGD
- ☐ I completed a General Practice Residency (GPR) program TRAININGGEN_GPR
- ☐ I am a Fellow of the Academy of General Dentistry (FAGD) TRAININGGEN_FAGD
- ☐ I completed Mastership in the Academy of General Dentistry (MAGD) TRAININGGEN_MAGD
- ☐ I completed some other advanced training program (please specify below) TRAININGGEN_OTHER

TRAININGGEN_OTHERTYPE

Previous Page  Continue  Save and Continue Later

**Questionnaire Instructions**

Previous Page  Continue

**26b. Please check all specialty training**

| | | |
|---|---|---|
| ☐ Endodontist | Year: _____ | TRAININGSPEC_ENDODONTIST<br>TRAININGSPEC_ENDODONTIST_YEAR |
| ☐ Pediatric Dentist | Year: _____ | TRAININGSPEC_PEDIATRIC |
| ☐ Periodontist | Year: _____ | TRAININGSPEC_PEDIATRIC_YEAR<br>TRAININGSPEC_PERIODONTIST |
| ☐ Prosthodontist | Year: _____ | TRAININGSPEC_PERIODONTIST_YEAR |
| ☐ Oral/Maxillofacial Surgeon | Year: _____ | TRAININGSPEC_PROSTHODONTIST<br>TRAININGSPEC_PROSTHODONTIST_YR |
| ☐ Orthodontist | Year: _____ | TRAININGSPEC_ORALMAXSURGEON<br>TRAININGSPEC_ORALMAXSURGEON_YR |
| ☐ Other (please specify below) | Year: _____ | TRAININGSPEC_ORTHODONTIST<br>TRAININGSPEC_ORTHODONTIST_YEAR |
| TRAININGSPEC_OTHERTYPE | | TRAININGSPEC_OTHER_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 MEMBERADA
- [ ] Academy of General Dentistry/state academy of general dentistry MEMBERACADGENERALDENTISTRY
- [ ] Other (please specify) MEMBEROTHER1
- [ ] Other (please specify) MEMBEROTHER2
- [ ] Other (please specify) MEMBEROTHER3
- [ ] Other (please specify) MEMBEROTHER4
- [ ] Other (please specify) MEMBEROTHER5
- [ ] None MEMBERNONE

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)** PATIENTSPERWEEK

_____ 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/licensed assistant.)**

| | 1<br>Not at all | 2<br>Occasionally | 3<br>Routinely |
|---|---|---|---|
| Non•implant restorative (amalgams, composites, crowns, veneers, bridges, posts, foundations, etc.)<br>MONTHLYNONIMPLANTSRESTOR | ○ | ○ | ○ |
| Implants (prosthetic and surgical procedures for implants)<br>MONTHLYIMPLANTS | ○ | ○ | ○ |
| Removable Prosthetics (full and partial dentures)<br>MONTHLYREMOVABLEPROSTHETICS | ○ | ○ | ○ |
| Extractions (surgical and non•surgical)<br>MONTHLYEXTRACTIONS | ○ | ○ | ○ |
| Periodontal therapy (non•surgical includes scaling/root planing that you do personally)<br>MONTHLYPERIODONTALNONSURGICAL | ○ | ○ | ○ |
| Periodontal therapy (surgical)<br>MONTHLYPERIODONTALSURGICAL | ○ | ○ | ○ |
| Endodontic therapy (anteriors/premolars)<br>MONTHLYENDODONTICPREMOLARS | ○ | ○ | ○ |
| Endodontic therapy (molars)<br>MONTHLYENDODONTICMOLARS | ○ | ○ | ○ |
| Procedures for esthetic reasons only (composites, crowns, veneers, etc.)<br>MONTHLYESTHETIC | ○ | ○ | ○ |
| Orthodontic treatment<br>MONTHLYORTHODONTIC | ○ | ○ | ○ |

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?**

WILLINGNESSSHAREELECRECORDS

1 ○ Yes

2 ○ Maybe, it depends on the study

3 ○ No

4 ○ 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.**

COMMENT

Previous Page  Continue  Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

**32. Please indicate the educational setting for your dental hygiene/dental therapist/licensed assistant training.** EDUCATIONSETTING

1 ○ Technical or community college

2 ○ Four•year college

3 ○ Alabama Dental Hygiene Program (ADHP)

4 ○ Other (please specify below)

EDUCATIONSETTING_OTHER

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

Previous Page Continue Save and Continue Later

**Questionnaire Instructions**

Previous Page Continue

**34. What is the highest degree you have obtained?** EDUCATIONHIGHESTDEGREE

1 ○ Certificate
2 ○ Associate
3 ○ Baccalaureate
4 ○ Master's
5 ○ PhD
6 ○ Other (please specify below)

EDUCATIONHIGHESTDEGREE_OTHER

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

☐ American Dental Hygienists Association MEMBERADHA ☐
State Dental Hygienists Association MEMBERSTATEDHA ☐
Study clubs MEMBERSTUDYCLUBS
☐ Other (please specify below) MEMBEROTHER
☐ None MEMBERNONEHG

MEMBEROTHER_TYPE

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) PERCENTPROPHYLAXIS | | % of patients |
| Periodontal therapy/scaling/root planing/periodontal maintenance PERCENTPERIODONTAL | | % of patients |
| Subgingival antimicrobial placement PERCENTSUBGINGIVAL | | % of patients |
| Restorative functions PERCENTRESTORATIVEFUNCTIONS | | % of patients |
| Local anesthesia (injection) PERCENTLOCANESTHESIAINJECTION | | % of patients |
| Local anesthesia (subgingival with a gel) PERCENTLOCANESTHESIAGEL | | % of patients |
| Dental sealants PERCENTSEALANTS | | % of patients |
| Dentinal desensitizers PERCENTDENTINALDESENSITIZERS | | % of patients |
| Radiographs PERCENTRADIOGRAPHS | | % of patients |
| Patient education (in•office) PERCENTEDUCATION | | % of patients |
| Tobacco cessation counseling PERCENTTOBACCO | | % of patients |
| Dietary counseling PERCENTDIETARY | | % of patients |
| Other (please specify below)PERCENTOTHER | | % of patients |

PERCENTOTHER_TYPE

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

Previous Page  Continue  Save and Continue Later

Questionnaire Instructions

Previous Page Continue

**38. Which category best describes you?** NONPRACTICECATEGORY

1 Dentist • Student
2 Dentist • Retired
3 Dentist • Awaiting U.S. license
4 Dentist • Between positions

5 Dental Hygienist/Dental Therapist/Licensed Assistant • Student
6 Dental Hygienist/Dental Therapist/Licensed Assistant • Retired
7 Dental Hygienist/Dental Therapist/Licensed Assistant • Awaiting U.S. license
8 Dental Hygienist/Dental Therapist/Licensed Assistant • Between positions

9 Educator
10 Researcher
11 Other (please specify below)

NONPRACTICECATEGORY_OTHER

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.

**Submit Survey** Return to Survey

Thank you for participating in dental practice•based research! You will receive a confirmation email shortly.

Practitioners who would like to participate in a National Dental PBRN study must complete Orientation Training. One option for completing Orientation Training is to view an orientation video. If you would like to view the orientation video now, followed by a quiz to receive 0.5 continuing education credits* and a Certificate of Completion, click here (estimated duration to complete: 30 minutes including the quiz). After viewing the video, you will need to sign•in to take the quiz and the following information should be entered:

Email address:
Last name:

If you prefer to view the orientation video at another time, you will be sent a follow•up email with further instructions.

*All participants are provided by email a certificate of completion. Continuing education credit awarded may not apply toward license renewal in all states. It is the responsibility of each participant to verify the requirement of his/her state license board(s).

**From:** National Dental
**Sent:** Wednesday, July 10, 2013 5:12 PM
**To:**
**Subject:** Confirmation of Enrollment Receipt and CE Credit Opportunities

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.

The network offers free Continuing Education (CE) credit as a membership benefit. The following CE credit opportunities are currently available.

1. *Orientation Training Video:* Practitioners who would like to participate in a National Dental PBRN study must complete Orientation Training. One option for completing Orientation Training is to view an orientation video. If you would like to view the orientation video, followed by a quiz to receive 0.5 CE credits* and a Certificate of Completion, here at any time.
2. *National Dental PBRN Presentation at the Institute for Oral Health (IOH) Meeting Video:* If you would like to view the National Dental PBRN presentation at the IOH meeting in October 2012 video, followed by a quiz to receive 0.5 CE credits* and a Certificate of Completion, click here at any time. This is an optional CE credit opportunity and is not a requirement as part of the enrollment process.

The estimated duration to complete each video is 30 minutes including the quiz. After viewing the video, you will need to sign-in to take the quiz and the following information should be entered:

Email address:
Last name:

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

*All participants are provided by email a certificate of completion. Continuing education credit awarded may not apply toward license renewal in all states. It is the responsibility of each participant to verify the requirement of his/her state license board(s).