



Health Systems Quality Assurance, Office of Community Health Systems  
**Dental Care Provider Survey**

To complete this survey online: <https://fortress.wa.gov/doh/opinio/s?s=HPSADentalCare>

DENTAL CARE PROVIDER SURVEY			
1. Last Name, Suffix (e.g. Sr., Jr.) _____		2. First Name _____	3. Middle Name _____
			4. Birth Year _____
5. Credentials:	<input type="checkbox"/> D.D.S. (Doctorate of Dental Surgery)		<input type="checkbox"/> D.M.D. (Doctorate of Dental Medicine)
6. Practice Name _____		7. Phone Number (_____) _____	
8. Practice Street Address _____		9. City _____	10. ZIP Code _____
		11. County _____	
12. Practice Mailing Address (if different) _____		13. City _____	14. ZIP Code _____
		15. County _____	
16. Primary Dental Care Type:	<input type="checkbox"/> General Dentistry		<input type="checkbox"/> Pediatric Dentistry
17. Dental Specialty: (Mark any that apply)	<input type="checkbox"/> Periodontics <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Endodontics		<input type="checkbox"/> Orthodontics <input type="checkbox"/> Prosthodontics <input type="checkbox"/> Other: _____
18. Provider Program or Status: (Mark any that apply)	<input type="checkbox"/> National Health Service Corps <input type="checkbox"/> State Loan Repayment/Scholarship <input type="checkbox"/> H-1B Visa Holder <input type="checkbox"/> Federal Employee (e.g. IHS, PHS)		<input type="checkbox"/> Resident or Intern <input type="checkbox"/> Faculty/Instructor/Research <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Other: _____
19. Within the next six months, does the dentist plan to:	<input type="checkbox"/> Retire <input type="checkbox"/> Move out of state <input type="checkbox"/> Decrease hours <input type="checkbox"/> Increase hours <input type="checkbox"/> Move to different practice <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
20. Please estimate the weekly hours this dentist spends on each of the following: (Please use whole numbers)	<b>Primary Dental Care:</b> _____ hours/week (Includes time spent preventative and routine, non-urgent dental health, and Pediatric Dentistry) <b>Specialty Dental Care:</b> _____ hours/week (Clinical care that includes Periodontics, Oral Surgery, Endodontics, Prosthodontics, Orthodontics) <b>Non-Clinical Duties:</b> _____ hours/week (Clinic administration, continuing education, lecturing, instruction, etc.)		
21. During an average week, please estimate the number of dental hygienists and/or dental assistants, and their combine hours, at this location. (employed or contracted)	Number of dental hygienists: _____	Number of dental assistants: _____	
	_____ Combined hours per week	_____ Combined hours per week	
22. In a typical workweek, please estimate the number of patients seen by this provider for primary dental care services.	Average number of patients: _____		

23. Please estimate the number of days it takes to schedule a routine, non-urgent appointment.	Established patients day(s) <input type="checkbox"/> < 5 days, <input type="checkbox"/> 5 to 10 days <input type="checkbox"/> 11 to 20 days <input type="checkbox"/> 21 to 30 days <input type="checkbox"/> > 30 days	New patients day(s) <input type="checkbox"/> < 5 days, <input type="checkbox"/> 5 to 10 days <input type="checkbox"/> 11 to 20 days <input type="checkbox"/> 21 to 30 days <input type="checkbox"/> > 30 days
24. On average, if the patient arrives on time for their appointment how many minutes does it typically take to see the dentist?	Established patients minutes(s) <input type="checkbox"/> < 5 minutes <input type="checkbox"/> 5 to 10 minutes <input type="checkbox"/> 11 to 20 minutes <input type="checkbox"/> 21 to 30 minutes <input type="checkbox"/> > 30 minutes	New patient(s) minute(s) <input type="checkbox"/> < 5 minutes <input type="checkbox"/> 5 to 10 minutes <input type="checkbox"/> 11 to 20 minutes <input type="checkbox"/> 21 to 30 minutes <input type="checkbox"/> > 30 minutes
25. How are multilingual interpretative services provided? (check all that apply)	<input type="checkbox"/> Clinic employee <input type="checkbox"/> Computer <input type="checkbox"/> None <input type="checkbox"/> Telephone <input type="checkbox"/> Family or friend <input type="checkbox"/> Other: _____ <input type="checkbox"/> Community Service <input type="checkbox"/> Unknown	
26. Does this provider serve the following patients? If yes, please estimate the percentage of the patient population.	Migrant Farm Workers: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ % (best estimate) Homeless People: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ % (best estimate) Apple Health (Medicaid): <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ % (best estimate) Sliding Fee Scale: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ % (best estimate)  Is the Sliding Fee Scale posted and visible to all patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure	
27. Is the dentist accepting:	Any new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes Any new Apple Health (Medicaid) patients? <input type="checkbox"/> No <input type="checkbox"/> Yes Any new Sliding Fee Scale patients? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Survey completed by:  Name: _____ Title: _____  Phone: _____ E-mail: _____  Questions: Contact Randy Saylor at (360)236-2865 or <a href="mailto:Randall.Saylor@doh.wa.gov">Randall.Saylor@doh.wa.gov</a> or Laura Olexa at (360)236-2811 or <a href="mailto:Laura.Olexa@doh.wa.gov">Laura.Olexa@doh.wa.gov</a>  Return by mail or fax to: Department of Health, Community Health Systems P.O. Box 47853 Olympia, WA 98504-7853 Fax (360)236-2830		