



# Dental Provider Survey

To complete this Survey online: <http://www.doh.wa.gov/hsqa/ocrh>

I - PROVIDER INFORMATION			
1. Last Name, Suffix (e.g. Sr., Jr.) _____	2. First Name _____	3. Middle Name _____	4. Birth Year _____
5. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unanswered			
6. Credentials:	<input type="checkbox"/> <b>D.D.S.</b> (Doctorate of Dental Surgery) <input type="checkbox"/> <b>D.M.D.</b> (Doctorate of Dental Medicine)		
A) 7. Primary Practice Name _____		8. Practice Phone Number _____	
9. Practice Street Address _____	10. City _____	11. Zip Code _____	12. County _____
9a. Practice Mailing Address _____	10a. City _____	11a. Zip Code _____	12a. County _____
Does provider have a secondary practice?			
B) _____		_____	
Secondary Practice Name, Address (Street, City, Zip Code) _____ County _____			
13. Primary Dental Care:	<input type="checkbox"/> General Dentistry <input type="checkbox"/> Pediatric Dentistry		
14. Dental Specialty: (Mark any that apply.)	<input type="checkbox"/> Periodontics <input type="checkbox"/> Orthodontics <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Prosthodontics <input type="checkbox"/> Endodontics <input type="checkbox"/> Other: _____		
15a. Is the provider a US citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	15b. If Provider is not a US citizen, what is the <b>current visa status</b> ? <input type="checkbox"/> J-1 Visa Waiver <input type="checkbox"/> Permanent US Resident (Green Card) <input type="checkbox"/> H-1B Visa Holder <input type="checkbox"/> Other Visa _____	
16. Provider Program: (Indicate which programs provider has participation.)	<input type="checkbox"/> Locum Tenens <input type="checkbox"/> State Loan Repayment /Program/Scholarship <input type="checkbox"/> Residency Program <input type="checkbox"/> Federal Employee (e.g. IHS, PHS) <input type="checkbox"/> Faculty <input type="checkbox"/> National Health Services Corps <input type="checkbox"/> None listed <input type="checkbox"/> Other _____		
17. Does the provider intend to <b>leave this practice within six months</b> : <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> Yes – explain: _____			
II - PRACTICE INFORMATION		Primary Practice	Secondary Practice
18a. How many <b>dental hygienists</b> work (employed or contract) at this primary practice?	_____ number of <b>dental hygienists</b>	_____ number of <b>dental hygienists</b>	
18b. What are the combined hours per week that the hygienists work?	_____ combined hours per week	_____ combined hours per week	
19a. How many <b>dental assistants</b> work (employed or contract) at this primary practice?	_____ number of <b>dental assistants</b>	_____ number of <b>dental assistants</b>	
19b. What are the combined hours per week that the assistants work?	_____ combined hours per week	_____ combined hours per week	
20. Please list the best <b>estimate of weekly hours</b> this provider spends on each of the following:  (Please list whole numbers)	<b>Primary Dental Care</b> _____ hours/week  <b>Specialty Dental Care</b> _____ hours/week  <b>Non-Clinical Care</b> _____ hours/week <i>(Clinic administration; continuing education, lecturing, vacations, etc.)</i>	<b>Primary Dental Care</b> _____ hours/week  <b>Specialty Dental Care</b> _____ hours/week  <b>Non-Clinical Care</b> _____ hours/week <i>(Clinic administration; continuing education, lecturing, vacations, etc.)</i>	
21. In a typical week, what is the <b>average number of patients</b> seen by this provider?	_____ average # of patients/week	_____ average # of patients/week	

<b>22.</b> On average, how long does it take to <b>schedule a routine, non-urgent appointment</b> ?	Current patients: _____ days, or _____ weeks New patients: _____ days, or _____ weeks	Current patients: _____ days, or _____ weeks New patients: _____ days, or _____ weeks
<b>23.</b> What <b>additional language(s)</b> besides English are spoken at this practice?	<input type="checkbox"/> None <input type="checkbox"/> Language(s) _____ _____	<input type="checkbox"/> None <input type="checkbox"/> Language(s) _____ _____
<b>24a.</b> Are <b>interpretative services</b> provided?	<input type="checkbox"/> None <input type="checkbox"/> Services: _____	<input type="checkbox"/> None <input type="checkbox"/> Services: _____
<b>24b.</b> How are <b>services</b> provided?	<input type="checkbox"/> None <input type="checkbox"/> Practice provides <input type="checkbox"/> Third party <input type="checkbox"/> Patient provides	<input type="checkbox"/> None <input type="checkbox"/> Practice provides <input type="checkbox"/> Third party <input type="checkbox"/> Patient provides
<b>25.</b> What <b>percentage</b> of the patient population is:  (Percentages can be estimate)	<b>a. Transitory agricultural migrant farm worker</b> and/or their dependents? <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Migrant _____ % <b>b. Homeless</b> and/or their dependents? <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Homeless _____ %	<b>a. Transitory agricultural migrant farm worker</b> and/or their dependents? <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Migrant _____ % <b>b. Homeless</b> and/or their dependents? <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Homeless _____ %

III - PAYER INFORMATION	Primary Practice	Secondary Practice
<b>26. Private Insurance</b>  Dental insurance through work or self-purchased.	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____
<b>27. Medicaid</b>  Federal and state administered payment for low income; include Fee for Service and Healthy Options.	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____
<b>28. Self-Pay Patients</b>  No dental insurance; patient pays full fees or given cash discount at time of service.	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____
<b>29a. Sliding Fee Scale (SFS)</b>  No dental insurance or subsidies; fees discounted according to income level; include charity.	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____
<b>29b.</b> Is the SFS <b>visibly posted and available</b> to all patients?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>30. Labor and Industries (L&amp;I)</b>  Worker's compensation	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____
<b>31. Other:</b> _____ (Please describe)	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____	_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____
Sum percentages should equal 100%	_____ % Payee Total for Primary Practice	_____ % Payee Total for Secondary Practice

**Comments:**

**Survey completed by:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Questions:** Phi Ly (360) 236-2825; **return to:** DOH, P.O. Box 47853, Olympia, WA 98504-7853, or fax (360) 236-2830