

Rhode Island General & Pediatric Dentist Survey

PLEASE COMPLETE ONE FORM FOR EACH DENTIST

(Correct label information as needed)

1. Dentist's Name: _____
2. Primary Practice Address: _____
3. Please indicate your practice type: General Dentistry _____ Pediatric Dentistry _____ Other _____
If other, please explain: _____
4. Do you practice at a single site? Yes _____ No _____ If no, please list your other practice address(es): _____
5. Are you a solo practitioner? Yes _____ No _____ If no, how many other dentists are in your practice? _____
6. Office Hours/Week: _____ Hours/Week Spent in **Direct Patient Care**: _____
7. Do you spend time in any of the following activities:
Administrative Duties: Yes _____ No _____ If yes, hours/week: _____
Teaching: Yes _____ No _____ If yes, hours/week: _____
Other (please describe): _____ If yes, hours/week: _____
8. Do you speak a language other than English: Yes _____ No _____
If yes, what language(s): _____
9. In the next year, are you planning to change practices and work at a different location within Rhode Island?
Yes _____ No _____
10. In the next year, are you planning to change practices and work outside of Rhode Island?
Yes _____ No _____
11. In the next year, are you planning to reduce the number of hours spent in direct patient care?
Yes _____ No _____
12. Do you plan to retire/sell your practice in the next:
Year _____ 2-5 years _____ 6-10 years _____ more than 10 years _____
13. Do you plan to hire an associate in the next:
Year _____ 2-5 years _____ 6-10 years _____ more than 10 years _____
14. In the past year, have you had difficulty hiring an associate? Yes _____ No _____
Please explain: _____
15. In the past year, have you had difficulty hiring dental hygienists? Yes _____ No _____
Please explain: _____
16. In the past year, have you had difficulty hiring dental assistants? Yes _____ No _____
Please explain: _____

Rhode Island General & Pediatric Dental Practice Survey

**PLEASE COMPLETE ONE FORM (COPY AS NEEDED)
FOR EACH PRACTICE SITE/ADDRESS**

Dentist Name: _____

Practice Address: _____

1. Please list all dentists working at this site (including yourself) and the number of hours of direct patient care per week at this site for each dentist:

Name _____ Hours Direct Pt. Care: _____

Name _____ Hours Direct Pt. Care: _____

Name _____ Hours Direct Pt. Care: _____

Name _____ Hours Direct Pt. Care: _____

Name _____ Hours Direct Pt. Care: _____

2. Are new patients currently being accepted at this site? Yes _____ No _____

3. Do new patients usually wait more than 6 weeks for an appointment for routine dental services? Yes _____ No _____

4. Approximately, how many active patients do you have at this practice site? Total # of patients: _____

Approximate # of RIteCare/Medicaid Patients: _____ Approximate # of uninsured patients: _____

5. Does the practice have a sliding fee schedule based on patient income? Yes _____ No _____

6. Is there a sign (posted visibly) in the waiting area to inform patients of sliding fee? Yes _____ No _____

7. Do you provide any pro-bono care to:

Children (through age 21) Yes _____ No _____ Pro-bono \$/year _____

Adults (age 22 and older) Yes _____ No _____ Pro-bono \$/year _____

8. Is the practice accepting new RIteCare/Medicaid patients? Yes _____ No _____

9. What changes to the current RIteCare/Medicaid program would entice you to increase participation?

Office Contact Person for Follow-up (if needed):

Name: _____ Phone: _____

Please take a few minutes to complete the surveys upon receipt. The completed surveys should be returned (ATTN: Carla Lundquist) on or before October 3, 2003 *by mail* (addressed stamped envelope enclosed) or *by fax* (401-222-4415). Questions may be directed to the Oral Health Program, Office of Primary Care, RI Department of Health. (Phone: 401-222-7626)