Wyoming Health Care Commission
Oral Health Study

Please assist the Wyoming Healthcare Commission in building a reliable database on Dentists. **Please take a moment to complete this survey.** Return by 11/01/2007 in the envelope provided or fax toll-free to (877) 290-0014. If you have any questions, please contact Rita toll-free at (877) 290-0021. Thank you.

Name: ______________________ **Prefix:** __________ **Suffix:** __________

Information collected for Health Alerts i.e., fax, email address, and telephone number is confidential and will be used only for health alert or public health related communications. Please provide a contact telephone number; keeping in mind that this will be kept **highly confidential** and used only in dire emergencies.
Preferred method of contact to receive Health Alerts. Indicate preference from 1 to 3 (1= Preferred Method):

__ **Fax:** __________ __ **E-mail:** __________ __ **Telephone:** __________

Email Address: ______________________ **Gender:** __________

Date of Birth: __________ **Birth Place State & Country:** __________

Year Began Practicing in Wyoming: __________

Ethnic Background: __ African American __ Asian __ Hispanic __ American Indian __ Caucasian/White ☐ Other: __________

Dental Specialty: __ **General Dentistry** __ Oral Surgery __ Periodontics __ Orthodontic __ Prosthodontic __ Oral Pathology __ Pediatrics __ Public Health __ Oral Maxillofacial Surgery Radiology __ Endodontic

Preferred Mailing Address: __ Home __ Primary Office

Overall Work Status in Wyoming:
(Hours engaged in dental activities)
__ >= 40 hours per week __ Left Area __ Inactive
__ 30-39 hours per week __ Retired __ Working in another field
__ <= 29 hours per week

In an average week, approximately how many hours do you work in each of the activities listed below?
___ Caring for Patients ___ Formal teaching ___ Administrative Positions
___ Research ___ Other Dental Activities __________

Current Academic Activity: __ Faculty Full-time __ Faculty Part-time __ Faculty Volunteer __ None

Home Address: ______________________

____

Educational Background:

High School: City: __________ State: __________ Country: __________

Undergraduate

University/College: __________

City: __________ State: _____ Country: __________
(if other than USA)

Date Graduated: __________ Degree Awarded: __________

Additional Undergraduate Degree

University/College: __________

City: __________ State: _____ Country: __________
(if other than USA)

Date Graduated: __________ Degree Awarded: __________

Dental School

University/College: __________

City: __________ State: _____ Country: __________
(if other than USA)

Date Graduated: __________ Degree Awarded: __________

Additional Dental School/College

University/College: __________

City: __________ State: _____ Country: __________
(if other than USA)

Date Graduated: __________ Degree Awarded: __________

Residency/Other

University/College: __________

City: __________ State: _____ Country: __________
(if other than USA)

Date Graduated: __________ Degree Awarded: __________

Additional Residency/Other

University/College: __________

City: __________ State: _____ Country: __________
(if other than USA)

Date Graduated: __________ Degree Awarded: __________

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Please note: Information from the following questions will only be made available as an aggregate and no individual specific information will be distributed.

Do you plan to sell your dental practice or retire from practicing dentistry? (check one)

__ In less than one year
__ In the next 6 - 10 years
__ Don't know / not sure
__ In the next 1 - 5 years
__ More than 10 years from now

Indicate which best describes the patient activity in your practice? (check all that apply)

__ Accept new Medicaid patients
__ Currently accept new patients
__ Actively seek new patients
__ Unable to accept new patients

Please describe your patient base by method of payment?

___ % Fee for service only
___ % Insurance
___ % Medicaid/SCHIP
___ % Other

On average, how long will it take for a new patient calling your office to get an appointment to see the dentist for an examination or treatment? (check one)

__ One week or less
__ More than two weeks, but less than four weeks
__ More than six weeks
__ More than one week, but less than two weeks
__ More than four weeks, but less than six weeks

Please complete the following information for ALL of your practice locations, i.e., primary practice, satellite, outreach and specialty clinics, emergency staffing and administrative positions. Please make additional copies of page 3 if necessary.

Practice Information:

Practice Name: ____________________

Address: ____________________

City/State/Zip ____________________

Phone: ____________________ **Fax:** ____________________ **Average weekly hours at this site:** __________

How would you best describe this practice setting? *(select one)*

__ Dental School/College
__ Hospital
__ Public Health Clinic
__ Student Health
__ Federal Institution
__ Private Office
__ State Institution

How would you best describe this practice arrangement? *(select one)*

__ Self-Employed - Partnership or Group
__ Salaried - Federal Government
__ Salaried - Other Dentist(s)
__ Self-Employed - Solo Practice
__ Salaried - Hospital (Non-Federal)
__ Salaried - Dental School/College
__ Salaried - State Government

Total number of Dental Hygienists working at this site:

___ >= 40 hrs/week
___ 30 - 39 hrs/week
___ 20 - 29 hrs/week
___ <= 19 hrs/week

Total number of Clinical Dental Assistants working at this site:

___ >= 40 hrs/week
___ 30 - 39 hrs/week
___ 20 - 29 hrs/week
___ <= 19 hrs/week

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Additional Practice Site Information:

Practice Name: ______________________________

Address: ______________________________

City/State/Zip ______________________________

Phone: ____________ **Fax:** ____________ **Average weekly hours at this site:** ______

How would you best describe this practice setting? *(select one)*

__ Dental School/College __ Hospital __ Public Health Clinic __ Student Health
__ Federal Institution __ Private Office __ State Institution

How would you best describe this practice arrangement? *(select one)*

__ Self-Employed - Partnership or Group __ Salaried - Federal Government __ Salaried - Other Dentist(s)
__ Self-Employed - Solo Practice __ Salaried - Hospital (Non-Federal)
__ Salaried - Dental School/College __ Salaried - State Government

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