



# UNIVERSITY OF FLORIDA

**Claude D. Pepper Center for Research on Oral Health and Aging**  
Office of the *Florida Dental Care Study* (FDSC)  
Health Science Center

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Dear Colleague:

As part of a major study about dental health and dental care conducted by the University of Florida and the National Institute of Dental Research, we would greatly appreciate it if you would complete this survey.

This is a study of national importance! Many publications have resulted from this study already, and we believe that this dental practice component will be very important.

This ongoing project, which began in 1993, is called the "Florida Dental Care Study". We have 873 subjects in the study, at least one of whom has identified you as one of their dentists, and who has given us written permission to abstract information from his or her dental record. Each of these persons was selected by chance.

We estimate that completing this survey will take about 30 minutes. As a token of our appreciation, upon receipt of a completed survey, we will send you a voucher toward any continuing education course offered by the University of Florida, regardless of its location.

This project has been reviewed and approved by the University of Florida Health Science Center Institutional Review Board for investigations involving human subjects. As such, we are required to keep your answers confidential. Results will be reported only as statistical summaries.

THANK YOU! If you have any questions, please call the Research Coordinator for the project, whose card is attached, or call me at (352) 392-2674.

With regards,

Gregg H. Gilbert, DDS  
Associate Professor  
Claude Pepper Center for Research on Oral Health in Aging

**check out the FDSC's Internet page!**

**<http://www.nerdc.ufl.edu/~gilbert>**

So that we can send you the continuing education voucher, please fill in your name, office address, telephone number, and today's date. Be assured that results will be reported only as statistical summaries, with no personal identifiers.

**Name:** Dr. \_\_\_\_\_

**Office address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Office telephone number:** \_\_\_\_\_

**Today's date:** \_\_\_\_\_

**1. Do you practice as a general dentist or as a specialist?** Please circle the appropriate answer.

1. General Practitioner
2. Oral/Maxillofacial Surgeon
3. Periodontist
4. Prosthodontist
5. Endodontist
6. other, please specify \_\_\_\_\_

**2. What is your current age?**

\_\_\_\_\_ years old

**3. Are you male or female?**

1. Male
2. Female

**4. What is your racial or ethnic identification?**

1. White, not of Hispanic origin
2. White, of Hispanic origin
3. Black, not of Hispanic Origin
4. Black, of Hispanic Origin
5. American Indian
6. Asian or Pacific Islander
7. Other (please specify) \_\_\_\_\_

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

19\_\_\_\_\_

**6. Which one of the following BEST describes your practice arrangement?**

1. Employed by another dentist
2. Self-employed without partners and without sharing of income, costs, or office space (one type of solo practice)
3. Self-employed without partners but share costs of office and/or assistants, etc (but with no income-sharing arrangements; another type of solo practice)
4. Self-employed as a partner in a complete partnership (both income and expenses shared)  
Including you the dentist, how many partners are there in the practice? \_\_\_\_\_ partners in the practice
5. Other: \_\_\_\_\_

**7. At how many dental practices, clinics, or hospitals do you (the dentist) care for patients at least once each week?**

1. One
2. Two
3. Three
4. More than three

**NOTE: IF YOU PRACTICE AT MORE THAN ONE LOCATION, PLEASE INCLUDE ALL THESE LOCATIONS WHEN ANSWERING THE FOLLOWING QUESTIONS.**

**8. Do you practice full-time or part-time, including all the locations at which you practice?**

1. full-time (32 or more hours per week)
2. part-time (less than 32 hours per week)

**9. How many hours do you personally (the dentist) spend per week in direct patient care, as opposed to management responsibilities?**

\_\_\_\_\_ hours in direct patient care

**10. How many people, including yourself, work full-time and how many work part-time in your part of the practice?** (e.g., if you and another dentist share equally a receptionist, then count that employee as 1/2 of an employee)

	full-time employees (32 + hours/week)	part-time employees (less than 32 hours/week)
dental hygienists	_____	_____
dental assistants	_____	_____
lab technicians	_____	_____
office manager, receptionist, other office personnel	_____	_____

**11. How many dental chairs do you, your assistant(s), and hygienist(s) use regularly in your part of the practice?**

\_\_\_\_\_ dental chairs

**12. How many patient visits do you personally (the dentist; NOT including your hygienist's patients) have during a typical work week?**

\_\_\_\_\_ patient visits in a typical week

**13. Approximately what percentage of the patients in your practice scheduled with you (the dentist) are ... ?**

Children & Teenagers (1 to 18 years)	_____%
Young adults (19 to 44 years)	_____%
Middle aged adults (45 to 64 years)	_____%
Elderly (65 or older)	_____%

[please check that this adds to 100%]

**14. Approximately what percentage of the patients in your practice scheduled with you (the dentist) are... ?**

White, not of Hispanic origin	_____%
Black, not of Hispanic origin	_____%
Hispanic	_____%
Asian descent	_____%
Other, please specify _____	_____%

[please check that this adds to 100%]

**15. Approximately what percentage of the patients in your practice scheduled with you (the dentist) are ... ?**

- Covered by a private insurance program that pays for some or all of their dental care? \_\_\_\_\_%
- Covered by a public program that pays for some or all of their dental care? \_\_\_\_\_%
- Not covered by any third party and pay their own bills? \_\_\_\_\_%
- Not covered by any third party and receive free care or for a fee that you reduce substantially? \_\_\_\_\_%  
[please check that this adds to 100%]

**16. Approximately what percentage of revenues are derived from different payment sources? If you do not accept certain payment procedures below, please record 0% in the column.**

<u>payment source</u>	<u>% of practice revenue from source</u>
dental insurance	_____%
self-pay	_____%
unpaid bills	_____%
other (please specify _____)	_____% [please check that this adds to 100%]

**17. What proportion of visits in your part of the practice are...?**

- Scheduled more than one day in advance \_\_\_\_\_%
- Emergency visits \_\_\_\_\_%  
[please check that this adds to 100%]

**18. Approximately what percentage of your patients have extended payment schedules?** If you do not accept extended payment schedules, please record 0% in the column.

\_\_\_\_% of patients on extended payment schedules (e.g., monthly payments)

**19. On average, how long does a patient in your practice have to wait:**

for a new patient exam appointment \_\_\_\_\_ days  
for a restorative dentistry appointment \_\_\_\_\_ days  
in the waiting room after arriving for an appointment \_\_\_\_\_ minutes

**20. Which of the following best describes your part of the practice during the past 12 months?**

- 1. Too busy to treat all people requesting appointments
- 2. Provided care to all who requested appointments, but the practice was overburdened
- 3. Provided care to all who requested appointments, and the practice was **not** overburdened
- 4. Not busy enough - the practice could have treated more patients

**21. Please record what percent of patient contact time you (the dentist, not your hygienist or other office staff) spend in a typical month performing the following procedures.** If you always refer these procedures to other practitioners, please record 0%.

Non-implant restorative (amalgams, composites, crowns, bridges, posts, foundations, etc.) \_\_\_\_\_%  
Implants (prosthetic and surgical procedures for implants) \_\_\_\_\_%  
Removable Prosthetics (full and partial dentures) \_\_\_\_\_%  
Extractions (surgical and non-surgical) \_\_\_\_\_%  
Periodontal therapy (surgical and non-surgical; includes scaling/root planing that you personally do) \_\_\_\_\_%  
Endodontic therapy (root canals and endo surgery) \_\_\_\_\_%  
Other (occlusal sealants, periodic & hygiene examinations, preventive dentistry, diagnostic, or other please specify \_\_\_\_\_) \_\_\_\_\_%

[please check that this adds to 100%]

**22. Please record what your typical fee is for a ...**

Please check below if you do **not** do this procedure

2-surface amalgam (ADA 2150)	\$ _____	_____
3-canal molar root canal (ADA 3310)	\$ _____	_____
Single uncomplicated extraction (ADA 7110)	\$ _____	_____
Cast partial denture (ADA 5213 or 5214)	\$ _____	_____
Full denture (ADA 5110 or 5120)	\$ _____	_____
Porcelain-to-metal crown (average of ADA 2750, 2751, 2752)	\$ _____	_____

**23. How many of your patients have dental extractions in a typical MONTH, or patients whom you refer for extractions ?**

\_\_\_\_\_ patients per MONTH

**24. For extractions that you do or recommend, other than wisdom teeth, deciduous teeth, or for orthodontic reasons, what percent are replaced eventually by a ... ?**

fixed bridge? \_\_\_\_\_%

removable partial or full denture? \_\_\_\_\_%

dental implant? \_\_\_\_\_%

not replaced? \_\_\_\_\_%

other \_\_\_\_\_%

(please specify \_\_\_\_\_)

[please check that this adds to 100%]

**25. What percent of these procedures do you (the dentist) refer to other dentists?**

Periodontal surgery	_____ % procedures <u>referred</u> to another dentist
Prosthetic crowns & bridges (other than implants)	_____ % procedures <u>referred</u> to another dentist
Implant surgery	_____ % procedures <u>referred</u> to another dentist
Implant restorations	_____ % procedures <u>referred</u> to another dentist
Full dentures	_____ % procedures <u>referred</u> to another dentist
Removable partial dentures	_____ % procedures <u>referred</u> to another dentist
Anterior tooth root canals	_____ % procedures <u>referred</u> to another dentist
Molar tooth root canals	_____ % procedures <u>referred</u> to another dentist
Endodontic surgery	_____ % procedures <u>referred</u> to another dentist
Non-surgical extractions	_____ % procedures <u>referred</u> to another dentist
Surgical extractions	_____ % procedures <u>referred</u> to another dentist
Orthodontics	_____ % procedures <u>referred</u> to another dentist

**26. Please indicate how true these statements are of the patients you personally (the dentist) see.**

- \_\_\_\_\_ % of my patients: Seek care soon enough.
- \_\_\_\_\_ % of my patients: Fear dentists.
- \_\_\_\_\_ % of my patients: Visit dentists more often than necessary.
- \_\_\_\_\_ % of my patients: Complain about waiting.
- \_\_\_\_\_ % of my patients: Pay their bills.
- \_\_\_\_\_ % of my patients: Follow advice about oral hygiene.
- \_\_\_\_\_ % of my patients: Show for appointments as scheduled.
- \_\_\_\_\_ % of my patients: Take responsibility for their oral health.
- \_\_\_\_\_ % of my patients: Treat me with the respect that I deserve.
- \_\_\_\_\_ % of my patients: Want to know details about the condition of their mouth.
- \_\_\_\_\_ % of my patients: Want to know details about their treatment options.
- \_\_\_\_\_ % of my patients: Use credit cards to pay for their dental treatment in my practice.

**27. To what extent do you agree or disagree with each item below? [Please put your answer (1-6) beside each statement.]**

<b>Very Strongly Disagree</b>	<b>Strongly Disagree</b>	<b>Somewhat Disagree</b>	<b>Somewhat Agree</b>	<b>Strongly Agree</b>	<b>Very Strongly Agree</b>	
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	
						_____
						_____
						_____
						_____
						_____

**28. On approximately what percent of patients do you or your staff do the following services at some time while they are patients in your practice?**

_____ % of my patients get:	Dental X-rays
_____ % of my patients get:	Diet counseling
_____ % of my patients get:	Blood pressure screening
_____ % of my patients get:	Oral cancer screening examination
_____ % of my patients get:	Oral hygiene instruction
_____ % of my patients get:	In-office fluoride application
_____ % of my patients get:	Fluoride gel/rinse prescribed or recommended for home use
_____ % of my patients get:	Patient education from written pamphlets
_____ % of my patients get:	Patient education from videos or slides
_____ % of my patients get:	Intraoral photographs taken (conventional, non-video photography)
_____ % of my patients get:	Intraoral video images taken (usually done with fiberoptic)

**PLEASE CONTINUE ON THE NEXT PAGE**



**We are learning a great deal from the Florida Dental Care Study.**

**THANK YOU FOR PARTICIPATING!**

**Is there anything important that we overlooked? Please use the space below for any additional comments that you would like to make about your dental practice.**