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### DENTAL SPECIALTY(IES) IN WHICH YOU SPEND MOST OF YOUR PROFESSIONAL TIME

Mark ONE principal specialty and ONE secondary specialty, if applicable.

Principal	Secondary	
<input type="radio"/>	<input type="radio"/>	General Dentistry
<input type="radio"/>	<input type="radio"/>	Dental Public Health
<input type="radio"/>	<input type="radio"/>	Endodontics
<input type="radio"/>	<input type="radio"/>	Oral and Maxillofacial Pathology
<input type="radio"/>	<input type="radio"/>	Oral and Maxillofacial Radiology
<input type="radio"/>	<input type="radio"/>	Oral and Maxillofacial Surgery
<input type="radio"/>	<input type="radio"/>	Orthodontics and Dentofacial Orthopedics
<input type="radio"/>	<input type="radio"/>	Pediatric Dentistry
<input type="radio"/>	<input type="radio"/>	Periodontics
<input type="radio"/>	<input type="radio"/>	Prosthodontics
<input type="radio"/>	<input type="radio"/>	Other

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### SPECIALTY BOARD CERTIFICATION

Have you obtained specialty education and received a certificate or met the requirements for certification by any of the following ADA recognized dental specialty boards?

Completed Residency Training	Board Certified	Board Eligible	(Mark all that apply.)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Dental Public Health
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Endodontics
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Oral and Maxillofacial Pathology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Oral and Maxillofacial Radiology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Oral and Maxillofacial Surgery
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Orthodontics
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Pediatric Dentistry
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Periodontology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Amer Bd of Prosthodontics

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### PRACTICE CAPACITY

Mark the statement that best describes your patient care practice status.

- I cannot accept any new/additional patients; my practice is full.
- I can accept some new/additional patients; my practice is nearly full.
- I can accept many new/additional patients; my practice is far from full.

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### AVAILABILITY OF DENTAL SERVICES

In your practice region, how would you characterize the supply of dentists in the following dental specialties? Mark only ONCE for each specialty.

No Shortage	Some Shortage	Critical Shortage	Don't Know	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	General Dentistry
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dental Public Health
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Endodontics
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Oral and Maxillofacial Pathology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Oral and Maxillofacial Radiology
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Oral and Maxillofacial Surgery
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Orthodontics and Dentofacial Orthopedics
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pediatric Dentistry
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Periodontics
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prosthodontics

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### NEAR FUTURE PRACTICE PLANS

In the next 12 months, do you plan to:

(Mark all that apply.)

- Stop providing patient care services?
- Significantly reduce your time spent in patient care?
- Move your practice to another location in New York?
- Move your practice out of New York?

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### INFORMATION TECHNOLOGY: HIPAA

Do you file claims electronically to follow Health Insurance Portability and Accountability Act (HIPAA) compliance requirements?

Yes  No

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### DENTAL PRACTICE INFORMATION ONLINE

The New York State Oral Health Plan is available online at: [http://www.health.state.ny.us/prevention/dental/oral\\_health\\_plan.htm](http://www.health.state.ny.us/prevention/dental/oral_health_plan.htm)  
To request a copy of the plan, call: (518) 474-1961.

For information concerning your professional practice, please visit the New York State Education Department Office of the Professions dental practice webpage at: <http://www.op.nysed.gov/dent.htm>

## New York State Education Department

### Dentist Survey

This questionnaire is a supplemental part of your registration application. Please complete and return it with the registration form and fee in the envelope provided.

Your responses will be maintained in a strictly confidential manner by the Center for Health Workforce Studies ([chws.albany.edu](http://chws.albany.edu)) at the University at Albany, SUNY. The responses will be analyzed and presented only in aggregate form. The responses will be analyzed in order to document changes in the dentist workforce in New York.

Item 2 asks for your NYS license number. This can be found on the enclosed registration application. Thank you for taking the time to complete this survey. If you complete the survey on-line, you do not have to complete this form.

#### INSTRUCTIONS

- Make dark marks that completely fill the circle.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

CORRECT: ●

INCORRECT:

#### 1 DATE ON WHICH YOU ARE COMPLETING SURVEY

A <input type="radio"/> Jan	<input type="radio"/> May	<input type="radio"/> Sep	B <input type="radio"/> 2010
<input type="radio"/> Feb	<input type="radio"/> Jun	<input type="radio"/> Oct	<input type="radio"/> 2011
<input type="radio"/> Mar	<input type="radio"/> Jul	<input type="radio"/> Nov	<input type="radio"/> 2012
<input type="radio"/> Apr	<input type="radio"/> Aug	<input type="radio"/> Dec	<input type="radio"/> 2013

#### 2 NYS LICENSE NO.

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

#### 3 GENDER

Male

Female

#### 4 YR OF BIRTH

1	9				
0	0				
1	1				
2	2				
3	3				
4	4				
5	5				
6	6				
7	7				
8	8				
9	9				

#### 5 RACE/ETHNICITY (Mark all that apply.)

- White
- African American/Black
- Native American/Alaska Native
- Asian/Pacific Islander
- Other race
- Hispanic/Latino?  
 Yes  
 No

**6 CURRENT WORK STATUS IN DENTISTRY**

- Full-time (30 hours or more per week)
- Part-time (less than 30 hours per week)
- Inactive in dentistry
- Retired

If retired, do you engage in volunteer dental work?  
 Yes  No

**NOTE: If you are inactive in dentistry or retired, STOP HERE and return the questionnaire with the registration form and fee in the envelope provided.**

**7 CURRENT ACTIVITIES IN DENTISTRY**

Please indicate hours per week in dentistry for which the major activity is:

	None	1-9	10-19	20-29	30-39	40-49	50+
Patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Research	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Teaching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Administration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**8 LOCATION OF EDUCATION**

Residence upon Graduation from High School	Location of Dental School from which you graduated	Location of most recent Dental Residency Training	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	New York
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other state in the US
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Canada
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other foreign country
	<input type="radio"/>	<input type="radio"/>	N/A

**9 LOCATION OF EDUCATION**

In what year did you graduate from dental school?

YR OF GRAD			
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you attended dental school in New York, indicate school:

- Columbia University
- New York University
- SUNY at Buffalo
- SUNY at Stony Brook

**10 PATIENT CARE: PRACTICE LOCATIONS**

Location of sites where you spend the most time providing direct patient care. Print the address of your practice location(s) including the 5-digit zip code. Also, indicate the average number of hours per week you spend at each practice location. Finally, include the average number of patient care hours per week provided by dental auxiliary staff at each practice location.

**Principal Location**

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Number  Street

City/Town  State

Zip Code	Your Patient Care Hours	Dental Hygienist Hours	Dental Assistant Hours
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Secondary Location**

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Number  Street

City/Town  State

Zip Code	Your Patient Care Hours	Dental Hygienist Hours	Dental Assistant Hours
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**11 PATIENT CARE: PRACTICE SITES**

What best describes the patient care practices you indicated in question 10? Mark one circle for principal and one for secondary practice location where applicable.

Principal	Secondary	
<input type="radio"/>	<input type="radio"/>	Private office - Solo practice
<input type="radio"/>	<input type="radio"/>	Private office - Partnership/Group practice
<input type="radio"/>	<input type="radio"/>	Hospital
<input type="radio"/>	<input type="radio"/>	Dental school/college
<input type="radio"/>	<input type="radio"/>	Public health clinic
<input type="radio"/>	<input type="radio"/>	Community health center
<input type="radio"/>	<input type="radio"/>	Nursing home
<input type="radio"/>	<input type="radio"/>	Federal, State, Local govt. institution
<input type="radio"/>	<input type="radio"/>	Other

**12 PATIENT CARE: PRACTICE SITES**

What best describes the practice arrangements at the locations you indicated in question 10? Mark one circle for principal and one for secondary practice location where applicable.

Principal	Secondary	
<input type="radio"/>	<input type="radio"/>	Self-employed/owner/partner
<input type="radio"/>	<input type="radio"/>	Salaried
<input type="radio"/>	<input type="radio"/>	Volunteer

**13 PATIENT CARE: INSURANCE COVERAGE**

What percent of your patients are in the following payment categories?

	Medicaid	Private Insurance	Self Pay	Unable to Pay
0%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1-4%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5-9%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10-19%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20-29%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30-39%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40-49%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50-59%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
60-69%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
70-79%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
80-89%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
90-100%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In the next 12 months, do you expect to increase the number of Medicaid patients you treat?  
 Yes  No  Don't know

S C A N T R O N - DE Mark Reflex@ EW-272258-2:654321 ED06