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

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

Principal	Secondary	
○	○	General Dentistry
○	○	Dental Public Health
○	○	Endodontics
○	○	Oral and Maxillofacial Pathology
○	○	Oral and Maxillofacial Radiology
○	○	Oral and Maxillofacial Surgery
○	○	Orthodontics and Dentofacial Orthopedics
○	○	Pediatric Dentistry
○	○	Periodontics
○	○	Prosthodontics
○	○	Other

15 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.)
○	○	○	Amer Bd of Dental Public Health
○	○	○	Amer Bd of Endodontics
○	○	○	Amer Bd of Oral and Maxillofacial Pathology
○	○	○	Amer Bd of Oral and Maxillofacial Radiology
○	○	○	Amer Bd of Oral and Maxillofacial Surgery
○	○	○	Amer Bd of Orthodontics
○	○	○	Amer Bd of Pediatric Dentistry
○	○	○	Amer Bd of Periodontology
○	○	○	Amer Bd of Prosthodontics

16 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.

17 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	
○	○	○	○	General Dentistry
○	○	○	○	Dental Public Health
○	○	○	○	Endodontics
○	○	○	○	Oral and Maxillofacial Pathology
○	○	○	○	Oral and Maxillofacial Radiology
○	○	○	○	Oral and Maxillofacial Surgery
○	○	○	○	Orthodontics and Dentofacial Orthopedics
○	○	○	○	Pediatric Dentistry
○	○	○	○	Periodontics
○	○	○	○	Prosthodontics

18 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?

19 INFORMATION TECHNOLOGY: HIPAA

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

○ Yes ○ No

20 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
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

SERIAL

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) 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				B	
○	Jan	○	May	○	Sep	○	2010
○	Feb	○	Jun	○	Oct	○	2011
○	Mar	○	Jul	○	Nov	○	2012
○	Apr	○	Aug	○	Dec	○	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:

	Hours/Week						
	None	1-9	10-19	20-29	30-39	40-49	50+
Patient care	◯	◯	◯	◯	◯	◯	◯
Research	◯	◯	◯	◯	◯	◯	◯
Teaching	◯	◯	◯	◯	◯	◯	◯
Administration	◯	◯	◯	◯	◯	◯	◯

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	
◯	◯	◯	New York
◯	◯	◯	Other state in the US
◯	◯	◯	Canada
◯	◯	◯	Other foreign country
		◯	N/A

9 LOCATION OF EDUCATION

In what year did you graduate from dental school?

YR OF GRAD: 0 0 0 / 1 1 1 / 2 2 2 / 3 3 3 / 4 4 4 / 5 5 5 / 6 6 6 / 7 7 7 / 8 8 8 / 9 9 9

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

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

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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

Number Street

City/Town State

Zip Code	Your Patient Care Hours	Dental Hygienist Hours	Dental Assistant Hours
0 0 0 0 0	0 0 0	0 0 0	0 0 0
1 1 1 1 1	1 1 1	1 1 1	1 1 1
2 2 2 2 2	2 2 2	2 2 2	2 2 2
3 3 3 3 3	3 3 3	3 3 3	3 3 3
4 4 4 4 4	4 4 4	4 4 4	4 4 4
5 5 5 5 5	5 5 5	5 5 5	5 5 5
6 6 6 6 6	6 6 6	6 6 6	6 6 6
7 7 7 7 7	7 7 7	7 7 7	7 7 7
8 8 8 8 8	8 8 8	8 8 8	8 8 8
9 9 9 9 9	9 9 9	9 9 9	9 9 9

Secondary Location

Number Street

City/Town State

Zip Code	Your Patient Care Hours	Dental Hygienist Hours	Dental Assistant Hours
0 0 0 0 0	0 0 0	0 0 0	0 0 0
1 1 1 1 1	1 1 1	1 1 1	1 1 1
2 2 2 2 2	2 2 2	2 2 2	2 2 2
3 3 3 3 3	3 3 3	3 3 3	3 3 3
4 4 4 4 4	4 4 4	4 4 4	4 4 4
5 5 5 5 5	5 5 5	5 5 5	5 5 5
6 6 6 6 6	6 6 6	6 6 6	6 6 6
7 7 7 7 7	7 7 7	7 7 7	7 7 7
8 8 8 8 8	8 8 8	8 8 8	8 8 8
9 9 9 9 9	9 9 9	9 9 9	9 9 9

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	
◯	◯	Private office - Solo practice
◯	◯	Private office - Partnership/Group practice
◯	◯	Hospital
◯	◯	Dental school/college
◯	◯	Public health clinic
◯	◯	Community health center
◯	◯	Nursing home
◯	◯	Federal, State, Local govt. institution
◯	◯	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	
◯	◯	Self-employed/owner/partner
◯	◯	Salaried
◯	◯	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%	◯	◯	◯	◯
1-4%	◯	◯	◯	◯
5-9%	◯	◯	◯	◯
10-19%	◯	◯	◯	◯
20-29%	◯	◯	◯	◯
30-39%	◯	◯	◯	◯
40-49%	◯	◯	◯	◯
50-59%	◯	◯	◯	◯
60-69%	◯	◯	◯	◯
70-79%	◯	◯	◯	◯
80-89%	◯	◯	◯	◯
90-100%	◯	◯	◯	◯

In the next 12 months, do you expect to increase the number of Medicaid patients you treat?

◯ Yes ◯ No ◯ Don't know