



Oral Health Needs Survey

* Michigan Oral Health Coalition*
Michigan Department of Community Health



Thank you for taking the time to complete this survey for us!

Please answer all questions from your perspective as an INDIVIDUAL practitioner

1. In addition to your Primary Clinic, do you practice/ consult at an additional clinic?

- Yes No

2. Please tell us in which county your Clinic(s) is located:

Primary Clinic _____

Additional Clinic _____

3. Please tell us about the type of primary / additional clinic you practice in

Description	Primary Clinic	Additional Clinic
A privately operated clinic (individual or group)	<input type="checkbox"/>	<input type="checkbox"/>
Hospital-based or other institutionally-based	<input type="checkbox"/>	<input type="checkbox"/>
Community Health Center	<input type="checkbox"/>	<input type="checkbox"/>
Health Department Dental Clinic	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify) : _____

4. Please tell us about your dental school training, certifications, and any current hospital or dental school affiliations.

- Dental school attended _____
- Year Graduated _____
- Post-graduate training (AEGD, GPR, specialty) _____
- Hospital affiliation _____
- Dental school affiliation _____
- Licensure status: active or inactive? _____

5. What types of payments are accepted at your primary / additional clinic?

Payment Type	Primary Clinic	Additional Clinic
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
Healthy Kids Dental	<input type="checkbox"/>	<input type="checkbox"/>
MI Child	<input type="checkbox"/>	<input type="checkbox"/>
Sliding Scale	<input type="checkbox"/>	<input type="checkbox"/>

Private Insurance: _____

6. Please indicate specialty:

- Endodontics
- Pediatric Dentistry
- Oral Surgery
- Periodontics
- Orthodontics
- Prosthodontics
- Public Health
- Other _____



7a. How many children (under 21) with disabilities would you say you treat per year?

- 0
- < 5
- 5 – 10
- 10 - 20
- 20 - 30
- > 30

7b. How many adults (21 and over) with disabilities would you say you treat per year?

- 0
- < 5
- 5 – 10
- 10 - 20
- 20 - 30
- > 30

7c. Have you had any special training for treating persons with disabilities?

- Yes
- No

7d. Have you ever treated a patient in a hospital setting?

- Yes
- No

7e. If you have treated patients in a hospital setting please tell us the age range of the patient you have treated.

- < 11 yrs
- 11 – 17 yrs
- 18 – 64 yrs
- 65+ yrs

7f. How long would you say the waiting period is for treating patients in a hospital setting?

- Immediate
- 1 month
- 2 – 3 months
- > 4 months

8. Please select the types of disabilities that you have experience with and the types of disabilities you are willing to accommodate.

Disability Condition	Experience with	Willing to treat
ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Autistic Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Acquired Neuromuscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Blindness/Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Deafness/Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Head/Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>
Speech and/or Language Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Oral/Touch Defensive	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify) _____



9. Which of the following accessibility features does your practice have to help persons with disabilities? (Select all that apply)

Features	Primary Clinic	Additional Clinic
Building and office is wheelchair accessible	<input type="checkbox"/>	<input type="checkbox"/>
Parking for people with special needs	<input type="checkbox"/>	<input type="checkbox"/>
Designated hours or days for persons with disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Allow guardian observation	<input type="checkbox"/>	<input type="checkbox"/>
Convenient location for public transportation	<input type="checkbox"/>	<input type="checkbox"/>
Easy transfer dental chair	<input type="checkbox"/>	<input type="checkbox"/>
Panorex X-Ray	<input type="checkbox"/>	<input type="checkbox"/>
Mobile equipment	<input type="checkbox"/>	<input type="checkbox"/>
American Sign Language	<input type="checkbox"/>	<input type="checkbox"/>

Languages other than English (please specify): _____

10. Do you provide on-site services to people who reside in nursing homes?

- Yes
- No

11. Do you provide services to people with disabilities in their own homes?

- Yes
- No

12. Do you work with a hygienist(s) or assistant(s) who have had special training and / or experience treating persons with disabilities?

Clinic	Yes	No
Primary	<input type="checkbox"/>	<input type="checkbox"/>
Additional	<input type="checkbox"/>	<input type="checkbox"/>

13. Which of the following behavioral and pharmacological techniques for pain and anxiety control do you use?

- None
- Relaxation management (TV, music, massage chair)
- Modified communication (including tell-show-do)
- Desensitization (office orientation visits)
- Facial massage
- Hypnotherapy
- Oral sedation
- Nitrous oxide-oxygen inhalation sedation
- Protective support (papoose board)
- IV (Intravenous sedation)
- IM (Intramuscular) sedation
- General anesthesia

14. Do you do anything different for pain and anxiety control? Please explain:

15. Please indicate the age ranges of the patients with disabilities that you have served. (Select all that apply)

- < 11 yrs
- 11 – 17 yrs
- 18 – 64 yrs
- 65+ yrs

16. Do you feel there is a lack of dentists who treat patients with disabilities in a hospital setting?

- Yes
- No

17. Have the recent changes in Medicaid reimbursement changed your willingness to practice within a hospital setting?

- Yes
- No



18. Please provide any other comments about the need for hospital dentistry including barriers that may prevent your clinic from offering care for persons with disabilities.

19. Do you have an interest in furthering your education on treating patients with special needs?

- No
 Yes (Please provide your name and contact info below)

Name: _____
Professional Degrees (DDS, DMD, MD, MBA, etc): _____

Phone: _____
Email: _____

20. Are you interested in being in a resource book as an oral health provider who treats persons with disabilities?

- Yes (Please go to question 21. Only information provided about clinic will be used in the resource book)
 No (No information provided by you will be disclosed)

21. Please provide the following information about your clinic(s).

Primary Clinic:

Additional Clinic:

Group or Practice Name: _____
Address 1 _____
Address 2 _____
City/Town _____
Zip Code _____
Phone _____
Email _____
Website _____
Office hours _____

Group or Practice Name: _____
Address 1 _____
Address 2 _____
City/Town _____
Zip Code _____
Phone _____
Email _____
Website _____
Office hours _____

Thank you!

