

GIVEKIDS A SMILE

## Event Feedback Form

**Your answers to this questionnaire will provide vital statistics for inclusion in access-to-care data and will help the Florida Dental Association (FDA) publicize the success of your *Give Kids A Smile* (GKAS) event(s).** Please fax your completed questionnaire within **two weeks after your GKAS event(s)** to the FDHF office at 850.681.0116. If you have any questions about this questionnaire, please call the FDHF, at 800.877.9922. Thank you for assistance in this effort.

The GKAS Coordinator should complete this form.

GKAS

Coordinator \_\_\_\_\_

Phone \_\_\_\_\_

E-mail \_\_\_\_\_

Affiliate Dental Association \_\_\_\_\_

1. What population did the GKAS event(s) in your area target?

- Local public school children
- Big Brothers/Big Sisters participants
- Boys and Girls Club participants
- Foster children
- Migrant children
- Other (please specify): \_\_\_\_\_

2. What ages were the children who attended your GKAS event(s)? Please include the number of children in each group.

Under age 5: \_\_\_\_\_

Ages 6 to 12: \_\_\_\_\_

Ages 13 to 18: \_\_\_\_\_

Ages 19 to 21: \_\_\_\_\_

All of the above: \_\_\_\_\_

3. How many dentists participated in your GKAS event(s)? \_\_\_\_\_

4. How many dental hygienists participated in your GKAS event(s)? \_\_\_\_\_

5. How many dental assistants participated in your GKAS event(s)? \_\_\_\_\_

6. How many children did you serve at your GKAS event(s)?

Extra rows are for recording multiple-site events. If you need more space, use the empty space at the end of this form.

Date of Event \_\_\_\_\_ Location of Event \_\_\_\_\_ Number of children served \_\_\_\_\_

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7. What type of dental care was provided at your GKAS event?

- Diagnostic dental care
- Preventive dental care
- Restorative dental care

8. What is the estimated value of the dental care provided during your GKAS event(s)? Are these values: UCR  or Medicaid .

• Diagnostic care Average value per child \_\_\_\_\_ Total value for event \_\_\_\_\_

• Preventive care Average value per child \_\_\_\_\_ Total value for event \_\_\_\_\_

• Restorative care Average value per child \_\_\_\_\_ Total value for event \_\_\_\_\_

GRAND TOTAL \_\_\_\_\_

9. How many No-shows did you encounter? \_\_\_\_\_

10. Were follow-up appointments scheduled with any of the GKAS participants?

- Yes  No

11. Did you work with the Florida Department of Health Volunteer Health Services Program Coordinator in your area to help you obtain sovereign immunity for GKAS?

- Yes  No

12. Describe any difficulties operating your GKAS event(s)?

13. Are there additional ways in which the FDHF can assist you in future GKAS event(s)?

14. Please list the county/counties for which you provided services:

15. Where did you hold your GKAS event(s)? If more than one site or location was involved. Please check all that apply and include the date(s) of the event(s) next to the appropriate location category.

- Public/community clinic Date: \_\_\_\_\_
- Private dentist's office Date: \_\_\_\_\_
- Public school Date: \_\_\_\_\_
- Community college Date: \_\_\_\_\_
- Other (please specify): Date: \_\_\_\_\_

16. Please list names of legislators and dignitaries that attended your GKAS event(s) and any media coverage that you used.

PLEASE INCLUDE a list of the dentists who participated in your Event.

REMINDER: Please send the details of your event  
and photographs to the FDA Membership & Communications Department.

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Fax: 850.201.5013 • E-mail: pharrison@floridadental.org

***On behalf of children statewide, the Florida Dental Health Foundation  
Project: Dentists Care Committee thanks you for your participation in this  
event.***

***We will compile this information and distribute to  
Legislators, media representatives and others.***