PRACTICE VALUATION QUESTIONNAIRE

GENERAL INFORMATION:

1-1. Name of Doctor (s) _____

1-2. Dental School Attended _____

_____

1-3. Year of Graduation _____

1-4. Office Address _____

_____

1-5. Office Telephone _____

1-6. Office Fax _____

1-7. Cell Phone _____

1-8. Email address (personal)_____

1-9. Website _____

1-10. Home Address _____

1-11. Home Telephone _____

May we contact you at your office? YES NO

1-12. May we fax you at your office: YES NO

1-13. Office Days/Hours _____

1-14. Average Office Hours Per Week _____

1-15. Number Of Days Worked By Owner Per Year _____

1-16. Type of Practice: General Dentistry Cosmetic/Restorative Multi-Specialty, Specialty e.g. Pediatric Dentistry, Endodontics, Oral Surgery, Orthodontics, Periodontics, Prosthodontics_____

1-17. How long has practice existed? _____ How long in this location?_____

1-18. Legal structure of practice e.g. sole proprietorship, limited liability corporation, partnership, Corporation _____

1-19. Do you have other practices or practice in another location? _____ Please specify. _____

1-20. The primary purpose of this valuation is:

Sale of Practice	Divorce
Transition Planning/Associate Buy-In/Partnership	Litigation
Partnership Dissolution	Other

1-21. If you are selling your practice:

A. What is your timeframe?

B. Are you willing to remain in the practice for some period of time? _____ If so, how long?

C. Are you willing to provide financing? __ If yes, what amount or percentage of the selling price?

D. Is your staff aware of your intentions?

1-22. Have any malpractice claims been made against you in the last five (5) years? _____ If yes, have they been settled? _____

1-23. Do you have the following equipment?

( ) Intra-Oral Camera(s) ( ) Imaging System

( ) Digital X-ray ( ) Panographic X-ray

1-24. Do you have practice software/computerization? _____Which software? _____

_____ How many terminals? _____

1-25. Please provide the name, email and telephone number for :

Accountant:_____

Attorney: _____

OPERATIONAL INFORMATION:

2-1. Please provide the following:

E. Current Active Patients (18 months) _____ Total Number of Patient Records _____

F. Clinical Visits Per Month Average _____

G. Hygiene Visits Per Month Average _____

H. New Patients Per Month Average _____

2-2. How many weeks are you scheduled in advance? _____

2-3. If you have an associate(s) or partner, how many weeks are they scheduled in advance? _____

2-4. Please provide the following regarding hygiene information:

Average Number of Hygiene Hours Per Week _____

Average Number of Hygiene Visits Per Week _____

Average Daily Hygiene Production _____

Do you have a non-surgical periodontal therapy program? _____

How many weeks in advance is Hygiene scheduled? _____

2-5. Do you currently employ an associate(s)? If yes, please provide the following:

Name _____

Date Hired _____

Hours Worked Per Week _____

Monthly Collections _____ % of total collections of the practice _____

Total Number of Associates _____

2-6. How is the Associate compensated?

Salary $_____

Percent of Collections _____

Percent of Production _____

Other, Please Explain _____

2-7. What is the average monthly compensation for the Associate(s)?_____

2-8. Are Associates bound by a restrictive covenant?

If yes, _____Miles, _____ Years

Non-Solicitation Agreement For _____ Years

2-9.What fringe benefits do you provide to your staff?

( ) Health Insurance. What Percentage? _____

( ) Uniforms

( ) Incentive Plan. Please Explain. _____

_____

_____

( )Pension Plan (Sarsep, 401K, Simple IRA, Defined Benefit, Money Purchase)

( )Transportation Allowance

( )Other Benefits _____

_____

_____

_____

2-10. Please Complete the Following Chart:

EMPLOYEE BENEFITS

Name	Position	Hourly Rate	Hours Per Week	Date of Hire	Health Benefits Monthly	Pension Benefits	Other Fringe Benefits

2-11. Are any of the practice staff family members? _____

3-1. Which services are routinely referred out of the practice?

( ) Endo
( ) Ortho
( ) Pedo
( ) Perio
( ) Oral Surgery
( )Implants
( )Other _____

ENVIRONMENTAL INFORMATION

3-2. The practice is located in which of the following areas?

{ } City/Downtown Location
{ } Suburban Location
{ } Industrial Location
{ } Commercial Location e.g. Shopping Mall, Shopping Center, etc.
{ } Commercial/Residential e.g. Condo, Residential Complex
{ } Rural

3-3. The practice is located on a:

{ }Two Lane Road/Street
{ }Four Lane Road/Street
{ }Six Lane Road/Street
{ }Other _____

3-4. Patient parking is which of the following?

{ }Adjacent Parking Lot (Free Parking) or Garage { }Commercial Lot/ Garage

{ }Street Parking { }Other_____

3-5. The population of your geographical area is:

{ }Growing

{ }Stable

{ }Decreasing

3-6. The overall Socio-Economic characteristics of your patients:

{ } Primarily Blue-Collar { } Primarily with Dental Insurance

{ } Primarily White Collar { } Primarily with/out Dental Insurance

3-7. Are there major employers from which a large portion of your patients are drawn? If yes, which ones?

_____

3-8. From what geographical communities do you draw most of your patients? _____

_____

3-9. From what sources do you receive patients?

{ Patient Referrals { Yellow Pages { Advertising { Insurance/PPO Participation

{ DHMO Participation , { Other sources _____

FACILITLY FACTORS

4-1. What is the approximate square footage of your office? _____

4-2. How many total operatories _____

{ }Clinical Dentistry { }Left Handed

{ }Hygiene { }Right Handed

{ }Finished, but not equipped

4-3. The Practice is Located in a:

{ }Multi-Tenant Professional Building

{ }General Office Building

{ }Stand-Alone Building (No Other Tenants)

{ }Combined Residence/Dental Office

{ }Other _____

4-4. Do you own, rent, share space? _____

4-5. If you own the building, do you pay yourself rent and what amount?_____

Is your rent at fair market value? _____ If not, what is the fair market value rent?_____

What is the estimated fair market value of the building? _____

Are you willing to sell the building? _____

What is your current mortgage balance? _____

4-6. Is your office location designed for access by the handicapped? _____

4-7. If you lease, how much is the monthly rent amount? _____

4-8. If you lease, when does the current lease term expire? _____

4-9. Do you have any renewal options in the lease? _____

4-10. Do you have monthly condo fees and what amount? _____

4-11. Given the age and condition of your equipment, furnishings, computer equipment, and overall facility, what do you anticipate you will need to spend for equipment, furnishings, or leasehold improvements in the next 12-36 months $_____

4-12. Do you anticipate a move to a new location in the next 12-36 months?_____

PRACTICE REVENUE

5-1. What are the primary **revenue** sources?

A. Dental Insurance/PPO Plans - _____%

B. Dental Capitation Plans - _____%

C. Other Third Party Sources - _____%

D. Direct from Patient - _____%

5-2. What percent of your **patients** come from the above sources?

A. Dental Insurance/PPO - _____%

B. Dental Capitation Plans - _____%

C. Other Third Party Payers - _____%

D. Self Pay Patients - _____%

5-3. Please list the dental networks in which you are contracted:

{ }Aetna/Prudential PPO
{ }Cigna
{ }Met Life PPO
{ }Guardian
{ }Delta Dental
{ }Blue Cross/Blue Shield
{ }United Concordia FFS
{ }United Concordia PPO
{ }Other

5-4. Please list the dental capitation plans in which you participate.

{ }Aetna DHMO
{ }Prudential DMO
{ }Cigna DHMO
{ }United Concordia DHMO
{ }Dental Benefit Providers
{ }Consumer Dental Plan
{ }The Dental Network
{ }Dominion Dental
{ }Other

5-5. Of the plans listed in 5-3 and 5-4, which represent the largest source of revenue to your practice? __

5-6. What is your current accounts receivable:

- From insurers, cap plans, third party payers - $_____
- From patients - $_____
- What percent of patient receivables is payment planned? _____

5-7 What is your total receivable by age group?

Current (1-29) days $_____

30-45 days $_____

45-60 days $_____

60-90 days $_____

Over 90 days $_____

5-8. To provide a sense of your fees, please provide the current fee for the following:

0120 Periodic Oral Evaluation $_____

0272 Bitewings – Two Films $_____

0110 Prophylaxis – Adult $_____

2391 Resin – 1 Surface $_____

2750 Crown $_____

4341 Perio Scaling & Rt. Planning $_____

5-9. What percentage of your total practice revenue is represented by the following:

A. Clinical Dentistry %_____

B. Hygiene %_____

How is the overall revenue broken down by procedures (needs to total 100%):

Hygiene ____ %
Perio _____%
Crown and Bridge_____%
Prosthodontics _____%
Ortho _____%
Other _____%
Oral Surgery _____%
Restorative _____%
Pedo _____%
Endo _____%
Implants _____%

DEBT SERVICE & EXISTING LEASES

6-1. Please list any debt service the dental practice currently owes:
Vendor/Bank _____

Monthly Payment _____

Balance Remaining _____

Any Lien on Equipment or Practice _____

6-2. Please list any leases in place for equipment.
Vendor/Bank _____

Monthly Payment _____

Remaining Term _____

Any Lien on Equipment or Practice _____

ADJUSTMENTS TO INCOME

7-1. To the best of your ability, please list those expenses that are attributed to your personal compensation.

	2014	2015	2016	2017
Salary				
Non working spouse/child salary				
Pension Plan Contrib by practice -owner				
Automobile Expenses				
Life Insurance-pd by practice				
Disability Insurance-pd by practice				
Health Insurance-pd by practice				
Travel & Entertainment				
Continuing Education				
Other				
Building Repairs & Maint.(if paid by the practice)				
Real Estate Taxes (if paid by the practice)				

Please provide any other pertinent information relative to your practice, which you believe should be considered. (Attach additional pages as necessary).

_____

_____

_____

_____

_____

We will also like the following practice reports:

Production by provider for each year and a year to date-identify the provider as owner, associate or hygienist. (at least the most recent two years)

Production by procedure for each year and a year to date

A year to date payroll report identifying the employee position

Please provide us with your signature below, indicating that to the best of your knowledge all of the information provided by you herein is true and accurate.

_____

DOCTOR'S SIGNATURE

_____

NAME (PRINT)

_____

DATE