PRACTICE PERFORMANCE DATA PACKET

SELLER NAME: _____

DATE: _____

The more information we have on your practice the better we can represent you and the practices. Please be as thorough as possible.

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PLEASE INCLUDE THE FOLLOWING DOCUMENTATION ALONG WITH THIS OUESTIONNAIRE

1. Copies of the last 3 years **FULL** corporate tax returns (or Schedule C with a list of "Other Expenses")

2. Profit and Loss Statements with Balance Sheet YTD through last complete month (accountant generated),

3. W2s for your staff for the last 3 years. Your CPA or Payroll service will have these.

4. The following reports from your computer software:
    a. Production by Procedure (Code) *by calendar year*
    b. Provider Productivity (To include production & collection by provider summary with YTD through last full month, total) by *calendar year*
    c. Patient Statistics Report (New Patients, Patients seen last 12 months, any patient profiling reports etc.).
    d. A Current Fee Schedule
    e. Summary Accounts Receivable Aging Report

5. A copy of Associate Agreement, where applicable

6. A list of all major *equipment, furniture and fixtures* broken down by room *(Example: Operatory #1, Reception Room, Business Office, etc.),* and any recent appraisals you may have had of these assets; **your full service supply dealer can appraise your "equipment in place" free of charge;**

7. Current Lease

8. Who are your advisors:

    Attorney Name: _____

    Phone: _____ E-mail: _____

    CPA Name: _____

    Phone: _____ E-mail: _____

May we contact the advisors with any questions regarding the transition? ☐ **Y ES** ☐ **NO**

Signature: _____

Date:_____

PERSONAL INFORMATION

Doctor's Full Name: _____
(First) (Middle) (Last) (Suffix)

Degree: ☐ DMD ☐ DDS ☐ Other: _____

Dental School _____Year Graduated: _____ Date of Birth: _____/_____/_____

Preferred Phone Number: _____ Confidential e-mail:_____

Home Mailing Address: _____

_____

Doctor's Corporate Name (if incorporated): _____

When does your corporate year end? _____

Practice 1 Name:_____
Address: _____

Office Telephone:

Practice 2

Name:_____

Address: _____

Office Telephone: _____

WEBSITE: _____

DESIRED TRANSITION

Please check the transition scenario that you desire the most:

- ☐ Sell *Part* of My Practice During the Next 0-3 Years
- ☐ Sell the *Entire* Practice Now & Work With the Buyer
- ☐ Sell the Entire Practice *Now* and Retire
- ☐ Have an Associate Work for Me Now, Then Sell the *Entire* Practice in 1 - 3 years

PRACTICE HISTORY, PATIENT PROFILE, HYGIENE

Years in Private Practice: _____ Years at Present Location: _____

Office Hours: Monday _____-_____ Tuesday _____-_____ Wednesday _____-_____
Thursday _____-_____ Friday _____-_____ Saturday _____-_____

Patient Profile: Average # of New Patients Seen/Month (excluding emergency-only patients): _____

Please provide the percentage of cases you **refer out** of the following (guesstimate if necessary):

_____ Endo _____ Simple Surgery _____ TMJ
_____ Ortho _____ Implant Placement _____Third Molar Surgery
_____ Pedo _____ Other (explain)_____

Estimate the percentage (out of 100%) of your total fees received from the following:

_____ Hygiene Services _____ Endo _____ TMJ
_____ Diagnostic _____ Operative _____ Perio Surgery
_____ Misc. _____ Removable _____ Crown & Bridge
_____ Ortho _____ Simple Surgery _____ Implant Placement

Crown and Bridge: Average Units per Month: _____ Average Lab Fee: $_____
Average Crown Fee: $_____

Your fees compared to others in your area are: ☐ Low ☐ Average ☐ High

Do you provide nitrous oxide?: ☐ Yes ☐ No

Estimate percentage of fees received from the following in your practice:

_____ Private Practice _____ Capitation (DMO/HMO) _____Insurance/Direct
_____ PPO _____ State Welfare (e.g.Medicaid) Reimbursement

Insurance: Please list all PPOs, prepaid plans, capitation plans, or HMOs you are involved with, and the approximate monthly checks you receive from them:

Name:	Amount:
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	**TOTAL** $ _____

EMPLOYEE INFORMATION

Indicate the number of employees you have in the following positions:

Front Desk:	Full-time: _____	Part-time: _____
Assistants:	Full-time: _____	Part-time: _____
Hygienists:	Full-time: _____	Part-time: _____
Technicians:	Full-time: _____	Part-time: _____

Others (describe):_____

Employee Profile: A breakdown of all employees by job description, listing **gross** salaries and benefits they receive: (List any additional employees on the back of this page or on a separate sheet of paper).

Employee Name	Position	Gross Salary	Benefits	Hire Date	Will Stay? Y or N	Full/Part time?	Age

PLEASE PROVIDE W2s FOR THE STAFF FOR THE LAST 3 YEARS

EMPLOYEE BENEFITS BREAKDOWN

PLEASE GIVE THE TOTAL COSTS **FOR STAFF ONLY** FOR THE LAST THREE (3) YEARS (**EXCLUDING DOCTOR, DOCTOR'S FAMILY MEMBERS OR ANY ASSOCIATES**):

Year	Health/Life Insurance	Education Allowance	Pension / Profit Sharing*
2015	$	$	$
2016	$	$	$
2017	$	$	$
2018 (YTD through last complete month)	$	$	$

Family members in your practice:

Are any of your family members employed / paid by the practice? ☐ Yes ☐ No

If your answer was "yes":

Name: _____

What is their role? _____

Monthly Salary: $ _____

Salary needed to replace family member: $ _____

List any benefits, if any: _____

_____

ASSOCIATE INFORMATION

Do you have other dentists working in your office? ☐ Yes ☐ No

If you have associates, please state the compensation detail, or those that have worked for you in the last 3 (three) years:

Dentist Name	W-2 or income paid in the last 3 years			Years in Employ	Salary or Percentage Paid (please explain)
---	2015	2016	2017	---	---

PLEASE PROVIDE US WITH A COPY OF ANY ASSOCIATE AGREEMENTS

FACILITY & LOCATION

Facility Ownership: ☐ Rent ☐ Own

Practice Location: ☐ Urban ☐ Suburban ☐ Rural

Location Growth: ☐ High Growth ☐ Moderate Growth ☐ Stable Growth

Facility Type: ☐ Free Standing ☐ Medical Complex ☐ Strip Shopping Center
☐ High Rise ☐ Anchor Tenant

Office Size – Treatment Rooms:

Total Square Footage: _____

Rooms Plumbed but Not Equipped: _____

Total # of Treatment Rooms: _____
Doctor Operatories: _____ # Hygiene Rooms: _____

Is the office expandable? ☐ Yes ☐ No

IF YOU RENT THE PREMISES REAL ESTATE:

Premises Rent: (If you do not own, answer the following)

Amount Paid / Month by Your Practice: $ _____
Original Lease Term: _____
Lease Expiration Date: _____
Describe Any Renewals: _____
_____

Condominium Fees: Do you presently pay any condominium association or maintenance fees that are not included in your rent figures? ☐Yes ☐No If yes, how much? $ _____

IF YOU OWN THE PREMISES REAL ESTATE:

What is the approximate value of the real estate? $ _____

Do you wish to sell the Premises Real Estate along with the sale of your practice? ☐ Yes ☐ No

If you answered "No," would you be willing to sell the Real Estate (for Fair Market Value) if the Purchaser required the real estate to be part of the purchase? ☐Yes ☐No

The Fair Market Monthly Rent*? $ _____

(*This should be an estimate of the fair market rent for your area. If uncertain, check with your CPA, real estate agents, and/or other professionals in your area who pay rent to a third party)

Amount Paid / Month by Your Practice: $ _____

What is the total: sq ft of the building? _____ Number of floors of the building? _____
What floor is the office located on? _____

EQUIPMENT & COMPUTER INFORMATION

What is the name of the full supply dealer? _____

Equipment Leases:

Do you have any equipment leases? (Dental equipment, telephone, computer, etc.) ☐Yes ☐No

If yes, please describe below:

Leased Item	Per Month Cost	Pay-off Date
	$	/ /
	$	/ /
	$	/ /

Major equipment expenditures in the last 3 three years (list):

Items Purchased	Date	Amount Spent
	/ /	$
	/ /	$
	/ /	$
	/ /	$

Computer Information:

Are you computerized? ☐ Yes ☐ No

If yes, what Practice Management Software? ☐ Dentrix ☐ Eaglesoft ☐ SoftDent ☐ Practice Works ☐ Other:_____

Is the office chartless/paperless? ☐ Yes ☐ No

Are you digital? ☐ Yes ☐ No

If yes, what digital system? ☐ Dexis ☐ Schick ☐ ScanX ☐ Other:_____

PRACTICE FINANCIAL INFORMATION

Outstanding Practice Debt: (exclude premises real estate):

Amount: $_____ for _____ _____

Approximate Date Debt Was Acquired: _____ _____

Approximate Date Debt Will Be Paid Off: _____ _____