Practice Appraisal Application

ADS South, Inc.
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Practice Appraisal Application

Owner Personal Information

Date of Preparation __________________ Reason for Appraisal ____

First Name ________________________ Middle Name ______________________ Last Name ________________________

Degree DDS _____ DMD _____ Other _____ Date of Birth ____________ Spouse's Name ____________________

Practice Trade Name ____

Corporation Suffix PC _____ PA _____ APDC _____ LLC _____ LLP _____ Other ________________________

Is Corporation a "C" or a "S" Corporation? C ____ S ____

Who is the Corporation President? ________________________________ Secretary ________________________________

Practice Street Address ____

City ____ State _______________________ Zip _______________

County/Parish ____

E-mail Address ______________________________________ Can we send private e-mail to you? ________________

Practice Phone Number ______________________________ Practice Fax Number ______________________________

Can we send private information to this number?

Pager Number ______________________________________ Cell Phone Number ________________________________

Home Phone Number __________________________________ Home Fax ____

Home Street Address ____

City ____ State _______________________ Zip _______________

Accountant Name ____

Accountant Street Address ____

City ____ State _______________________ Zip _______________

Accountant E-Mail ____

Accountant Phone ___________________________________ Accountant Fax ____________________________________

Attorney Name ______________________________________ Attorney Firm Name _________________________________

Attorney Street Address ____

City ____ State _______________________ Zip _______________

Attorney E-Mail ____

Attorney Phone ______________________________________ Attorney Fax _______________________________________

Leasing Company ____

Leasing Agent Name ____

Leasing Agent Street Address ____

City ____ State _______________________ Zip _______________

Leasing Agent Phone _________________________________ Leasing Agent Fax __________________________________

How did you hear about ADS South? ____

____

List of Items Required

Please forward the following items as soon as possible:

_________ Last three years Schedule C from personal tax return or if you are a corporation, U.S. Tax Return Form 1120 or 1120S. **Include Schedule 1 and Balance Sheet for above plus all supporting statements of "other" expenses.**

_________ Year-to-date accounting statements (profit and loss) for the latest period of the current year.

_________ Complete list of all major items to be included in the sale and date of acquisition of major items. (Use list on last page.)

_________ A copy of your office lease.

_________ Appraisal fee of $2,500 ($1,000 if seller listing agreement is signed).

_________ First page of bank statements since beginning of current year.

_________ Copies of any equipment leases.

_________ Copy of your current fee schedule and fee schedule for any plans.

_________ Copy of contracts with any associates, partners, or employees.

_________ Previous year's W-2 forms for employees.

_________ Photographs of all rooms and exterior of office.

_________ A diagram of the office layout -- may be hand drawn.

_________ Have Chamber of Commerce mail ADS a newcomer pack.

_________ Dentist section of your local Yellow Pages.

Circle your urgency in selling practice. ("10" represents selling in 30 days. "1" represents selling in 2 years.)

1 2 3 4 5 6 7 8 9 10

Personal Data

Dental School Alma Mater ______________________________

Year Graduated ______________________________

Year Beginning Practice in City ____________________ Year Beginning Practice in Location ______________

Right or Left Handed ____________________ Purchase or Scratch Start ____________________

Professional Organizations ______________________________

Post Graduate Degree ______________________________

Date Completed ______________________________

Alma Mater ______________________________

Specialty or Designations ______________________________

____

____

Do you have an associate? ____________________ Do you share space? ____________________

Do you have a partner? ____________________ Is there a written agreement? ____________________

Is there a buy-out agreement? ____________________ Is there a restrictive covenant? ____________________

Office Data

Office Sq. Footage ____________________ Expandable Footage ____________________

Current Monthly Rental Amount ____________________ Is Office Handicapped Accessible? ____________________

Number of Parking Spaces ____________________ Proximity of Parking ____________________

Number of Operatories Equipped for Dentist __________ Number of Operatories Equipped for Hygienist ______

Number of Plumbed But Unequipped Operatories ______ Number of Unplumbed Empty Operatories __________

If you do not own your office, provide: Date of Lease ______________ Date Lease Ends ______________

Term in Years ____________ Years Remaining on Lease ______________ Renewal Options ______________

Do you own your office? ____________________ Do you want to sell the building? ____________________

What price? ____________________ If Not for Sale, Monthly Rental Amount ______________

Annual Taxes ____________________ Annual Insurance ____________________

Post-Sale Information

Plans After Sale of Practice ____

____

____

Days/Week Currently Worked ________

Enter Desired Days Worked for New Buyer Sale

Desired Work Days/Week 1st Year ________

Desired Work Days/Week 2nd Year ________

Desired Work Days/Week 3rd Year ________

Desired Work Days/Week 4th Year ________

Desired Work Days/Week 5th Year ________

Desired Work Days/Week 6th Year ________

Enter Desired Days Worked for Merger Sale

Desired Work Days/Week 1st Year ________

Desired Work Days/Week 2nd Year ________

Desired Work Days/Week 3rd Year ________

Desired Work Days/Week 4th Year ________

Desired Work Days/Week 5th Year ________

Desired Work Days/Week 6th Year ________

Practice Data

Have you used a consultant in the past five years? ______ Who? ______________________________

Results ____

____

____

Describe any internal marketing ____

____

____

Has your practice gross changed significantly? ______________________________

Why? ____

____

Number of active patients (different patients in last 18 months) ______________________________

If accurate number is not known, measure number of patient records in 3 feet of records, divide by 3 and multiply by number of feet of records.

Avg number new patients per month ______________________________

Avg number patients / day by dentist ______________________________

Avg number patients / day by hygienist ______________________________

How far ahead is dentist scheduled? ______________________________

How far ahead is hygienist scheduled? ______________________________

Practice Data

% Practice Income from Cash ___________
% of Patients Paying Cash ___________
% Practice Income from Insurance ___________
% of Patients with Insurance ___________
% Practice Income from HMO ___________
% of Patients with HMO ___________
% Practice Income from PPO ___________
% of Patients with PPO ___________
% Practice Income from Capitation ___________
% of Patients with Capitation ___________
% Practice Income from Medicaid ___________
% of Patients with Medicaid ___________
% Practice Income with Reduced Fee Plan ___________
% of Patients with with Reduced Fee Plans ___________

Office Hours:

Monday ________________
Tuesday ________________
Wednesday ________________
Thursday ________________
Friday ________________
Saturday ________________

Scheduling Data:

DDS Hours Worked/Week ________________
Hygiene Hours Worked/Week ________________
Associate Hours Worked/Week ________________
Dentist Patient Visits Per Year ________________
Hygiene Patient Visits Per Year ________________
Number of Days Worked Per Year ________________
Number of Weeks Worked Per Year ________________
Actual Accounts Receivable Balance ________________
What is Your Collection Percentage? ________________
What Type Recall System? ____
What Type Computer System? ____

What % of the Practice Income is:

Hygienist Production ___________
Operative ___________
Pedodontics ___________
Orthodontics ___________
Implants ___________
Removable Prosthetics ___________
Fixed Prosthetics ___________
Endodontics ___________
Periodontics ___________
Oral Surgery ___________
Cosmetic ___________
TMJ Treatment ___________
Soft Tissue Management ___________
Other _______________ ___________
TOTAL (the above should total) 100%

Fee Schedule

Adult Prophy 01110 $______________
Gold Inlay 02540 $______________
Two Surface Posterior Composite 02386 $______________
Two Surface Amalgam 02150 $______________
Core Build-Up Including Pins 02950 $______________
Gold/Porcelain Crown 02750 $______________
Anterior Canal Root Canal 03310 $______________
Bicuspid Root Canal 03320 $______________
Labial Porcelain Veneer 02962 $______________

Demographic Data

What is the approximate population of your city or town? ______________

What is the approximate population of your drawing area? ______________

Number of dentists within 5 miles ______________

Number of new dentists within 5 miles in the last 5 years? ______________

Major employers in the area ______________

____

Describe any major economic changes in your drawing area ______________

____

Staff Data

Describe Staff By Position As To:	Annual Salary	Will Possibly Stay?	Year Hired
Receptionist			
Office Manager			
Bookkeeper			
Assistant			
Assistant			
Assistant			
Assistant			
Assistant			
Hygienist			
Hygienist			
Hygienist			
Hygienist			
Lab Technician			
Lab Technician			
Other ______________			
Other ______________			

Describe Fringe Benefits and Value ______________

Do You Hire Any Unpaid Family? Who? ______________

Describe Duties ______________

Estimated Annual Value of Above ______________

Production Centers

	Year to Date _____________ to _____________	Last Year	Two Years Ago
Gross Production	_____________	_________________	______________
Hygienists	_____________	_________________	______________
Owner	_____________	_________________	______________
Associate	_____________	_________________	______________
Associate	_____________	_________________	______________
Associate	_____________	_________________	______________

	Salary	Commission
How is associate compensated? Amount?	$______________________	____________________%
	Salary	Commission
How is hygienist compensated? Amount?	$______________________	____________________%

Practice Conformity Data

Does practice meet OSHA standards? ____

Why not? ____

____

____

Does practice meet CDC guidelines? ____

Why Not? ____

____

____

Does practice conform with all governmental requirements? ____

Why not? ____

____

____

Have you received any disciplinary actions in the past seven years? ____

Explain ____

____

____

Have you had any practice-related lawsuits filed against you in the past ten years? ____

Explain ____

____

____

Describe any health problems which would affect practice of dentistry ____

____

____

Describe your practice, staff, patients, community and practice philosophy ____

____

____

____

____

Specialty Practice Supplement for Orthodontic and Oral Surgery

Orthodontic Specialty Practice

Total number of patients in treatment ______

Complete banding treatment patients ______ Partial banding treatment patients ______

Patients in retention ______ Patients in TMJ treatment ______

______

Current account balance ______ Accounts receivable balance (money past due) $______

Number of patients in treatment no longer paying fees ______

Cost of average full treatment: Child ______ Adult ______

New starts this year as of Jan. 1, ______ New starts in last twelve (12) months ______

Average down payment for records ______ Banding ______

Average fee per visit $______ Number of patients treated at no charge______

Number of patients in retention ______ Average fee per retention: Initial $_____ Periodic $_____

Number of patients in partial treatment: Adult ______ Child ______

Average fee for partial treatment:: Adult $______ Child $______

Number of patients in TMJ treatment: Adult ______ Child ______

Average fee for TMJ treatment: Adult $______ Child $______

Do you use: Begg _____% Edgewise _____% Other _____% Describe ______

______

Describe technique, banding, etc. most commonly used: ______

______

What percent of practice is referred from: Other dentists _____% By patients _____%

Any other information that would be helpful in describing your practice ______

______

______

______

Oral Surgery Specialty Practice

What percent of practice is: Exodontia _____% Maxillofacial _____% TMJ _____%

Trauma _____% Other _____% Describe ______

Describe typical anesthesia technique for in-office surgery: ______

______

______

At what hospitals do you have privileges? ______

______

Describe your referral sources (number, ages, etc.) ______

______

______

Any other information that would be helpful in describing your practice ______

______

______

Equipment List

Reception

personal	corporation	quantity	description	
				Waiting Room Chairs
				Waiting Room Tables
				Waiting Room Lamps
				Pictures/Decorations
				Other
				Other
				Other

Business Office

personal	corporation	quantity	description	
				Business Office Desk
				Business Office Chair
				Copy Machine
				File Cabinets
				Typewriter
				Computer
				Printer
				Software
				Other
				Other
				Other

Private Office

personal	corporation	quantity	description	
				Desk
				Chair
				Bookcase
				Other
				Other
				Other

Lounge

personal	corporation	quantity	description	
				Refrigerator
				Table & Chairs
				Microwave
				Other
				Other
				Other

Mechanical

personal	corporation	quantity	description	
				Compressor
				Vacuum Pump
				Other
				Other
				Other

X-Ray Equipment

personal	corporation	quantity	description	
				Panorex X-Ray
				Film Processor
				Developing Tank
				Other
				Other
				Other

Tanks

personal	corporation	quantity	description	
				Nitrous Manifold System
				Tank Valves
				Air Dryer
				Other
				Other
				Other

Lab

personal	corporation	quantity	description	
				Model Trimmer
				Lathe
				Furnace
				Splash Hood with Shield
				Vibrator
				Casting Machine
				Suck Down Unit
				Wax Dripping Pot
				Porcelain & Opaque
				Powder Mixer
				Articulators
				Surveyor
				Plastic Bins

Lab Continued

personal	corporation	quantity	description	
				Vacuum Pump
				Lab Handpieces
				Other
				Other

Sterilization

personal	corporation	quantity	description	
				Auto Clave
				Ultrasonic Cleaner
				Other
				Other

Hygiene #1

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor's Stool
				Assistant's Stool
				Lights
				Mobile Carts
				Prophy Jet
				Cavitron
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Hygiene #2

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor's Stool
				Assistant's Stool
				Lights
				Mobile Carts
				Prophy Jet
				Cavitron
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Hygiene #3

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor's Stool
				Assistant's Stool
				Lights
				Mobile Carts
				Prophy Jet
				Cavitron
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Hygiene #4

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor’s Stool
				Assistant’s Stool
				Lights
				Mobile Carts
				Prophy Jet
				Cavitron
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Operatory #1

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor’s Stool
				Assistant’s Stool
				Lights
				Mobile Carts
				Prophy Jet
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Operatory #2

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor’s Stool
				Assistant’s Stool
				Lights
				Mobile Carts
				Prophy Jet
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Operatory #3

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor’s Stool
				Assistant’s Stool
				Lights
				Mobile Carts
				Prophy Jet
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Operatory #4

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor’s Stool
				Assistant’s Stool
				Lights
				Mobile Carts
				Prophy Jet
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Operatory #5

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor’s Stool
				Assistant’s Stool
				Lights
				Mobile Carts
				Prophy Jet
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

Operatory #6

personal	corporation	quantity	description	
				Patient Chair
				Dental Units
				Doctor’s Stool
				Assistant’s Stool
				Lights
				Mobile Carts
				Prophy Jet
				High Speed Handpieces
				Low Speed Handpieces
				Misc. Handpieces
				Burs
				Curing Light
				Cabinets
				X-Ray Units
				X-Ray View Box
				Nitrous Flow Meter
				Amalgamator
				Other
				Other
				Other

List any other equipment to be included:

____

____

____

____

List any items not to be included:

____

____

____

____

Office Layout

Please provide diagram of office layout (may be hand drawn).