Primary Practice Questionnaire Form

1. Doctor & Practice Details

• Doctor's Complete Name:

____

• Degree:

____

• License Number:

____

• Date of Birth:

____

• Email Address:

____

• Best Phone Number (Home / Office / Cell):

____

• Practice Legal Name:

____

• Dental School Attended:

____

• Office Address (Street, City, State, ZIP):

____

• Mailing Address (if different):

____

• Accountant's Name & Phone:

____

• Attorney's Name & Phone:

____

• Dental Supply Company:

____

2. Practice Overview

• Years in practice:

____

• Years at current location:

____

• Type of practice (Solo / Partnership / Group / Other):

____

• Number of doctors in practice:

____

• Do you have an associate? (Yes / No):

____

• If yes, do they have a written contract? (Yes / No):

____

• If yes, is there a non-compete? (Yes / No):

____

• How often do you provide re-work treatment?

____

• Reason for selling:

____

____

Office Hours:

Day	Office Open	Doctor Hours	Hygiene Hours	Associate Hours
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

3. Financial & Patient Data

Total Collections and Hygiene Collections (Last 3 Years):

Year	Total Collections ($)	Hygiene Collections ($)
Year 1		
Year 2		
Year 3		

Type of Patient and Source of Income

Type of Insurance	Percentage
PPO	
FFS	
HMO-Medicare	
Medicaid	

• Monthly CAP Check Received:

___

• Number of Active Patient Files (seen within last 2 years):

___

• Number of New Patients Monthly:

___

• Average Patients Seen per Day:

___

4. Staff & Operations

• Number of Hygiene Days per Week:

___

• Describe your recall system (Pre-appoint, Card Sent, Mix):

___

___

Staff Details:

Position & Full Name	FT/PT	Hourly/Salary	Years Employed	Will Remain
Front Desk				
Assistants				
Hygienists				

Position & Full Name	FT/PT	Hourly/Salary	Years Employed	Will Remain
Others				

• Benefits provided to staff (check all that apply): Life Insurance / Sick Pay / Retirement / Medical / Uniform / Profit Sharing / Other

____

5. Services & Procedures

Percentage of Income by Service Type:

Service Type	Percentage of Income (%)
Hygiene	
Perio	
Operative and/or Restauration	
Endo	
Implants	
Crown & Bridge	
Surgery	
Removable (Dentures, etc)	
Other	

• Percentage of procedures referred out (Ortho, Pedo, Endo, etc.):

____

• Average monthly referred cases:

____

• Specialized services performed (Botox, Sleep Apnea, Ortho, TMJ, Invisalign, IV Sedation):

____

6. Office & Equipment

• Office Square Footage:

____

• Lease Term, Expiration, Renewal Option:

____

• Total Monthly Rent:

____

• Number of Equipped Treatment Rooms / Chairs:

____

• Utilities (Electric, Water, Trash):

____

• List major equipment (owned or leased):

____

_Office Management Sofware:

____

___

• Items not included in sale (personal property):

____

___

____

___

7. Compliance & Financial Overview

• Is your office OSHA compliant? (Yes / No)

____

• Last OSHA Training Date:

____

• Office Management Software:

____

• OSHA Manager:

____

• Attach 2 years of tax returns and P&L statements.

____

Accounts Receivable Breakdown:

Category	Amount ($)
Current	
30 Days	

Category	Amount ($)
60 Days	
90+ Days	
Total	

• Estimated Collection Rate (%):

____

Yearly Expenses Breakdown:

Expense Type	Annual Cost ($)
Malpractice Insurance	
General Insurance	
Disability Insurance	
Office Overhead	
Other	