

N/L Transitions

Dental Practice Transition Questionnaire

Personal Information

Name of Seller if
an Individual:

Name of Seller if
a Corporation or
LLC:

Home Address:

Work Address:

Home Phone:

() _____

Work Phone:

() _____

Mobile Phone:

() _____

Fax Number:

() _____

Please circle
preferred method
of contact

E-mail Address:

Website:

Dental School
Attended:

Year of
Graduation:

Name of Attorney:

Phone Number:

Email Address:

Name of

Accountant:

Phone Number:

() _____

Email Address:

N/L Transitions

Dental Practice History and Characteristics

General Office Information

1) What is your practice specialty?

(a) General Dentistry:

(b) Oral Surgery:

(c) Periodontics:

(d) Endodontics:

(e) Prosthodontics:

(f) Pedodontics:

2) If a General practice, what services do you offer?

(a) Oral Surgery:

(b) Periodontics:

(c) Endodontics:

(d) Cosmetic Dentistry:

(e) Restorative Dentistry:

N/L Transitions

3) Office hours?

(a) Monday:

(b) Tuesday:

(c) Wednesday:

(d) Thursday:

(e) Friday:

(f) Saturday:

(g) Sunday:

4) How long has the practice been in existence?

5) How long have you been at this location?

6) What practice management software do you use?

7) What new, modern-day equipment do you use? Ex.
Panorex, digital radiography, intraoral camera, etc.

7a) Are they included in the sale? yes no

7b) List any equipment exclusions:

N/L Transitions

8) What is the reason for selling the practice?

(a) Retirement:

- Are you planning on staying in the area? yes no

(b) Relocation:

(c) Sale of second location:

(d) Financial distress:

(e) Dental license revocation:

(f) Illness/Disability:

(g) Death:

9) May we contact you at your office? yes no

10) May we fax you at your office? yes no

11) Is your staff aware of your intention to sell? yes no

12) What is the legal structure of your practice?

a) Sole Proprietorship

b) Limited Liability Company

c) Partnership

d) Corporation

N/L Transitions

13) Do you practice in another location? yes no

14) If yes, please specify location: _____

Operational Information

1) Approximately how many patient records do you have? _____

2) Approximately how many of those are active patients, having been seen in the last 18 months? _____

3) What is your average number of clinical visits per month? _____

4) How many new patients do you see a month? _____

5) How many weeks in advance is/are the doctor(s) scheduled in advance? _____

6) What is the average number of hours per week of hygiene? _____

7) What is the average number of hygiene visits per week? _____

N/L Transitions

8) How many weeks in advance is hygiene scheduled? _____

9) Do you have a non-surgical periodontal therapy program? yes no

10) What benefits does the practice offer to the staff?

(a) Uniform allowance:

(b) Health insurance:

(c) 401K:

(d) Continuing education:

(e) Paid vacations: If so, how many weeks: _____

(f) Sick leave: If so, how many hours: _____

(g) Other: _____

11) List the number of staff positions, length of employment and salary:

	Number of Staff	Date of Hire	Salary/Hourly Wage
(a) Office manager:	_____	_____	_____
(b) Front desk:	_____	_____	_____
	_____	_____	_____
(c) Hygienists:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

N/L Transitions

Date of Hire

Salary/Hourly Wage

(d) Dental Assistants:

(e) Bookkeeper:

(f) Lab personnel:

(g) Are any of the staff family members?

yes

no

If so, how many: _____

12) What services does the practice refer to specialists?

13) List all contracts that the practice is a party to that are NOT cancelable on 30 days or less notice.

14) List any debt service the practice currently owes

15) List any equipment leases the practice currently owes

N/L Transitions

16) Are there any associates in the practice?

yes no

a) If so, how many?

b) If so, how many days does each associate work?

c) How many days in advance is each associate scheduled?

17) List the associates (attach additional sheets if necessary)

General:

Name: _____

Date Hired: _____

Hours worked/week: _____

Monthly Production: _____

Compensation:

Salary: \$ _____

% of Production: _____

% of Collections: _____

N/L Transitions

Other arrangements: _____ (Please explain)

Average monthly compensation: _____

Restrictive Covenants:

Is the associate bound by a contract and restrictive covenants?

yes no

If yes: _____ Miles

_____ Years

Does the associate have a non-solicitation agreement?

yes no

If yes: _____ Years

N/L Transitions

Demographic Information

1) In what kind of environment is the practice located?

(a) Suburban:

(b) Downtown:

(c) Four lane road:

(d) Two lane road:

(e) Main street:

(f) Urban:

(g) Shopping Mall

(h) Condominium

2) Is practice in a growing or stagnant area?

3) How many dental practices are in the immediate area (2 square miles)?

4) Is patient base primarily white or blue collared?

5) Does patient base primarily have insurance?

6) Name the major employers in the area:

7) Do patients come to the practice from outside immediate areas?
If so, from where?

N/L Transitions

8) List the patient demographics by age and zip codes:
Please attach software report

9) From what sources do you receive patients?

- a) Advertising
- b) Yellow Pages
- c) Patient Referrals
- d) Insurance/PPO
- e) HMO
- f) Speaking engagement
- g) Other

10) Is the population of your area:

- a) Stable
- b) Growing
- c) Decreasing

Facility Factors

1) What is the square footage of the dental office? _____

2) How many operatories are in the practice?

(a) # of operatories for dentists: _____

(b) # of operatories for hygienists: _____

(c) # of emergency operatories: _____

(d) # of plumbed operatories but not built out: _____

(e) # of right-handed operatories _____

(f) # of left-handed operatories _____

N/L Transitions

3) Age of equipment in each operatory:

(a) Operatory #1

(b) Operatory #2:

(c) Operatory #3:

(d) Operatory #4:

(e) Operatory #5:

4) Is there room to expand?

yes no

If yes, by how many operatories?

5) What kind of building is the practice located in?

6) What is the availability of patient parking (paid or free)?

7) Is your office handicapped accessible?

yes no

8) Is the facility leased or owned?

(a) If owned, do you wish to sell the facility? yes no

(b) If owned, is there a loan? yes no

(c) If so, it is assumable? yes no

N/L Transitions

9) If leased, when does the current lease expire?

10) If leased, are there any lease options?

yes no

If yes, how many and for how long:

11) How much is the current monthly base rent?

12) Is there a condo fee?

yes no If yes: \$_____/month

13) How much will you need to spend for new equipment, furnishings and leasehold improvements in the next 3 years?

Practice Revenue Information

1) List by percent how the practice derives its primary revenue:

(a) Fee for service:

(b) Dental insurance:

- What dental networks or PPO plans does the practice participate in?

- a) Aetna PPO
- b) Met Life
- c) Cigna
- d) Guardian
- e) Delta Dental
- Delta Premier
- f) CareFirst BC/BS
- g) United Concordia
- h) Other: _____

- Which of the PPO plans represents the practice's largest source of revenue?

N/L Transitions

(c) Dental capitation:

- What dental capitation plans does the practice participate in?

2) List by percent how the practice derives its primary patient sources:

(a) Referrals:

(b) Dental PPO:

(c) Dental Capitation Plans:

(d) Marketing:

3) The total accounts receivable of the practice is \$_____ and is aged as follows:

(a) Current:

(b) 30 days:

(c) 60 days:

(d) 90 days or over:

N/L Transitions

4) What percentage of the accounts receivable is payment plans?

5) What is the maximum amount of time you consider a receivable to be collectible?

6) What are the total account receivables in a second party collection agency?

7) Please provide a fee schedule

8) What percent of the practice revenue is generated from hygiene?

9) What percentage of the practice revenue is generated from clinical dentistry?

10) Are you currently involved in any litigation not covered by insurance? yes no

11) What percentage of the total practice revenue is overhead?

N/L Transitions

List of Needed Items

1. Most recent 3 years of practice federal and state income tax returns, including most recent detailed depreciation schedule
2. Copies of CPA prepared financial statements for the same periods (or internally prepared P&L if necessary) and year-to-date for the current year
3. Annual production reports for the same periods and year-to-date for the current year showing production, adjustments, collections by provider by procedure (or by procedure by provider)
4. Annual production reports for the same periods and year-to-date for the current year showing production, adjustments, collections by payor (by insurance company, etc.)
5. Copies of the W-2's for most recent 3 years and a list of the employees for each year denoting their position, average hours worked/week, hourly rate and benefits they receive.
**Please note if any related parties work for the practice that don't receive a W-2*
6. Copy of the most recent personal property tax return for the practice (if applicable)
7. Lease agreements
8. Copy of practice valuation report and/or practice profile for the practice, if available
9. Associate agreements
10. Fee Schedule
11. Any other information about the practice

To the best of your knowledge, all of the information provided by you herein is true and accurate.

Date

Dentist Signature

Dentist Name (Print)