



PHASE II ASSOCIATES
PRACTICE LIMITED TO SPECIALTY TRANSITIONS

PERIODODONTIC

PRACTICE APPRAISAL

APPLICATION

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MEMBERS OF:



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Owner Personal Information

Date: _____ Reason for Appraisal _____

First Name _____ Middle Name _____ Last Name _____

Degree: DDS _____ DMD _____ Other _____ Specialty _____

Date of Birth _____ Spouse's Name _____

Practice Trade Name _____

Company Suffix PC _____ PA _____ APDC _____ LLC _____ LLP _____ Other _____

Is Corporation a "C" or an "S" Corporation? C _____ S _____

Who is 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 _____

Cell Phone Number _____

Home Phone Number _____ Home Fax Number _____

Home Address _____

City _____ State _____ Zip _____

Accountant Name _____

Accountant Address _____

City _____ State _____ Zip _____

Accountant E-mail _____

Accountant Phone _____ Accountant Fax Number _____

Attorney Name _____ Firm Name _____

Attorney Address _____

City _____ State _____ Zip _____

Attorney e-mail _____

Attorney Phone Number _____ Fax Number _____

Leasing Company _____

Leasing Agent Name _____

Leasing Company Address _____

Leasing Agent Phone _____ Leasing Agent Fax _____

List of Items Required

The Following Items are Needed for the Practice Appraisal:

1. _____ Last **three** (3) years Schedule C from personal tax returns 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.**
2. _____ Year-to-Date accounting statements (Profit & Loss) and balance sheet for the latest period of the current year.
3. _____ Complete list of all equipment, furniture and fixtures to be included in the appraisal and date of acquisition of major items. This includes all depreciation schedules.
4. _____ A copy of your office lease.
5. _____ Appraisal fee of \$5,000.
6. _____ First Page of bank statements since beginning of current year.
7. _____ Copies of any equipment leases.
8. _____ Copy of your current fee schedule and a fee schedule for any dental plans.
9. _____ Copy of contracts with any associates, partners, or employees.
10. _____ Previous year's W-2 forms for employees.
11. _____ Photographs of all rooms and exterior of office.
12. _____ A diagram of the office layout – may be hand drawn.

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

How did you hear about Phase II Associates? _____

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 Space _____

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 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 your Internal Marketing _____

Has your practice gross changed significantly? _____

Why _____

Average number of new patients per month _____ Average number patients/day by Periodontist _____

Average number of patients/day by hygienist _____ How far ahead is Periodontist scheduled? _____

How far ahead is hygienist scheduled? _____

% 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 from Reduced Fee Plans _____

% of Patients 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 Software? _____

What % of the Practice Income is:

Hygienist Production _____

Other _____

Please Attach a Copy of your Fee Schedule to this Report.

Demographic Data

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

What is the approximate population of your drawing area? _____

Number of periodontists practicing within 5 mile radius? _____

Number of **NEW** periodontists practicing your specialty within 5 mile radius in 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	_____	_____	_____
Receptionist	_____	_____	_____
Receptionist	_____	_____	_____
Receptionist	_____	_____	_____
Office Manager	_____	_____	_____
Bookkeeper	_____	_____	_____
Treatment Coordinator	_____	_____	_____
Assistant	_____	_____	_____
Assistant	_____	_____	_____
Assistant	_____	_____	_____
Assistant	_____	_____	_____
Assistant	_____	_____	_____

Describe Staff by Position as to:	Annual Salary	Will Possibly Stay	Year Hired
Associate Periodontist	_____	_____	_____
Associate Periodontist	_____	_____	_____
Hygienist	_____	_____	_____
Hygienist	_____	_____	_____
Hygienist	_____	_____	_____
Hygienist	_____	_____	_____
Lab Technician	_____	_____	_____
Lab Technician	_____	_____	_____
Other _____	_____	_____	_____
Other _____	_____	_____	_____

Describe Fringe Benefits and Value _____

Do You Hire any Unpaid Family? _____

Describe Duties _____

Estimated Value of Unpaid Family _____

Production Centers

	Year to Date	Last Year	Two Years Ago
	_____ to _____	_____	_____
Gross Production	_____	_____	_____
Owner Production	_____	_____	_____
Owner Production	_____	_____	_____
Owner Production	_____	_____	_____
Owner Production	_____	_____	_____
Hygiene Production	_____	_____	_____
Hygiene Production	_____	_____	_____
Hygiene Production	_____	_____	_____
Associate Production	_____	_____	_____
Associate Production	_____	_____	_____

How is Associate Compensated? _____

How is Hygienist Compensated? _____

Practice Conformity Data

Does Practice Meet OSHA Standards? _____

Why Not? _____

Does Practice Meet CDC Guidelines? _____

Why Not? _____

Does Practice Conform with All Government 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

Office Layout

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

List procedures and % of practice

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Anesthesia

Describe typical anesthesia technique for in-office surgeries

Referrals

What percentage of the practice is referred from:

Dentists _____ **Patients** _____

Describe your referral sources: (numbers, ages etc.)

Describe your marketing plan for the referring dentists
