

Dental Practice Information Report

In addition to the information listed in this report, the following practice reports are required to pursue loan approval (please provide an explanation if any of these reports are unavailable):

- ✓ **Accounts Receivable Aging Summary**
- ✓ **Current Year Production by Service Type Report**
- ✓ **Current Year Production by Provider Report**

Date _____

Practice Owner's Name: _____

Name of Practice: _____ Type of Practice: _____

Address: _____
City County State Zip

Telephone: () _____ () _____
Office Phone Fax Web Address

1. History

Date practice established: _____ Date purchased by current owner: _____

2. Practice Sale

Why is the practice being sold and what are the owner's plans after the sale (work as associate, retire, etc.)?

3. Office Hours

Monday: _____ Tuesday: _____

Wednesday: _____ Thursday: _____

Friday: _____ Weekends: _____

4. Office Building

Owner: _____

Address: _____
City State Zip

Is the building being sold with the practice? _____ If so, for how much? _____

Equipped Operatories? _____ Available Operatories? _____ Room for expansion? _____

Square footage of office space: _____ Current monthly rent rate: \$ _____

Remaining term of lease (including tenant option to renew): _____

5. Accounts Receivable (please attach A/R summary)

Current Credit Balance \$ _____

6. Practice Make-Up

% receipts from owner: _____ % receipts from associate(s): _____

** % receipts from hygienist: _____ % receipts from specialist(s): _____

% hygiene receipts related to periodontal therapy: _____ ** excluding doctor exam fees

Fee-for-service (% receipts): _____ Capitation/HMO (% receipts): _____

Welfare (% receipts): _____ PPO (% receipts): _____

Cash/Check (% receipts): _____ Credit Card (% receipts): _____

Capitation/HMO (% patient base): _____ Welfare (% patient base): _____

Adults (% patient base) _____ Children (% patient base): _____

7. Patient Numbers

What is the average number of new patients seen per month? _____ Is Ceric utilized: _____

How much time do you allow for: Crown prep _____ Hygiene appointment _____

Is anesthesia a part of the practice: _____ Do you utilize expanded function staff: _____

8. Recalls

Do you have a soft tissue management program? _____ If yes, please describe: _____

Current actual recalls per month: _____ Number of clients on recall: _____

9. Office Procedures

Do you waive co-pays for any individuals or group of individuals? _____

Does the office provide care to a single employer or group that represents 15% or more of total practice revenue? If yes, please provide the percentage and background information on the group.

Staff					
Name	Position	Rate of Pay	Hours/Week	Tenure	Benefits

Are any family members getting paid through the Practice? _____ If yes, what are their combined wages? _____

Please complete the following for Specialty Practices only:

New patient flow:

Referring Dentist _____ % Word of mouth _____ %
 Marketing _____ % Other _____ %

- # of dentists referring 100+ cases per year _____
- # of dentists referring 50-99 cases per year _____
- # of dentists referring 25-49 cases per year _____
- # of dentists referring fewer then 25 cases per year _____

ESTIMATED age of top 15 referring dentist:

- # over age 60 _____
- # in their 50's _____
- # in their 40's _____
- # less than 40 _____