

Data Collection Form

SELLER'S INFORMATION

Seller's Name: _____ Office Phone: _____
Practice Name: _____ Mobile Phone: _____
Office Address: _____ Email Address: _____
City, State, Zip: _____ Is the office staff aware of the sale? Yes No
Reason for sale of practice? _____ Current Dental Supply Company: _____

PRACTICE TRANSITION DATA

Seller has been at location for how many years? _____ Will Seller remain after the sale? Yes No If yes, how many months? _____
Practice has been in existence for how many years? _____ Are there any lienholders Yes No
Does the Seller own any other practices? Yes No If yes, distance between practices? _____
If Seller's practice is a specialty practice, please explain: _____
Types of procedures currently referred out: _____
Does the practice have an associate? Yes No If yes, percentage of gross sales from associate(s) production? _____
Will associate be retained? Yes No Does the practice have a hygienist? Yes No
Collection sources last 12 months? Office pmt: _____ % Insurance: _____ % Medicaid _____ % Capitation _____
Office hours: Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____

FINANCIAL

What were your gross collections?:

2007: \$ _____ 2008: \$ _____ 2009: \$ _____

What were your variable expenses (wages, payroll tax, laboratory, supplies, etc.)?

2007: \$ _____ 2008: \$ _____ 2009: \$ _____

What were your fixed expenses (rent, utilities, phones, insurance, legal, etc.)?

2007: \$ _____ 2008: \$ _____ 2009: \$ _____

BUILDING INFORMATION

Does the Seller own the building? Yes No Total sq. ft. of building: _____ Total number of floors: _____

Total number operatories? _____ # equipped? _____ # doctor operatories? _____ # hygiene rooms? _____ R/L Handed _____

Condition of equipment: Excellent Good Poor Average age of equipment? _____

Is the office computerized? Yes No Type of software: _____

Does the practice need new equipment? Yes No If yes, explain _____

Does the practice need leasehold improvements? Yes No If yes, explain _____

LEASE INFORMATION

Monthly rent \$ _____ Original lease term (yrs) _____ Lease expiration date: _____

Renewal option Yes No Number of years: _____ Purchase option Yes No Date: _____

Lease renewal amount/month \$ _____ Purchase option amount \$ _____ Can this lease be assigned? Yes No

Landlord Name: _____ Landlord Phone #: _____

PRACTICE PERFORMANCE

Procedure	% of Production	Procedure	% of Production	Number of active patient records
Hygiene	_____ %	Orthodontics	_____ %	Total patient records _____
Restorative	_____ %	Oral Surgery	_____ %	Average age of patients _____
Crown & Bridge	_____ %	Other _____	_____ %	New Patients Per Month _____
Endodontics	_____ %	Other _____	_____ %	Source _____
Periodontics	_____ %	Other _____	_____ %	How is seller's practice currently promoted (i.e. yellow pages, TV etc.)?
Removable Prosthodontics	_____ %	Other _____	_____ %	_____

OFFICE STAFF INFORMATION

Position	Days/Week	Hire Date	Salary/Production	Benefits	Staying?
Office Manager	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Assistant	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Associate	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Hygienist	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Receptionist	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Is Seller related to any office staff? Yes No If yes, explain _____