



Practice Transitions Made Perfect™

CONFIDENTIAL VALUATION PROFILE

Upon completion or if you have any questions, please contact your local representative:

Southeast Florida - Stuart M. Auerbach, DDS
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Central and North Florida – Paul Rang, DMD, JD
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ADS Florida, LLC
Licensed Real Estate Broker
999 Vanderbilt Beach Road, Suite 200 | Naples, Florida 34108
Phone / Fax: 800.262.4119

Date: _____ Practice Type: General Endodontist Oral Surgeon Orthodontist
 Pediatric Periodontist Prosthodontist

Desired Transaction: Sell & Leave Associate/Partner Buy-In Sell Practice & Associate Other: _____

Name: _____ DDS DMD
First Middle/Maiden Last

Date of Birth: ____/____/____

Spouses Name: _____
First Middle/Maiden Last

Practice Trade Name: _____ PA PC INC

Are You Incorporated? Yes: Schedule C or Sub-Chapter S or Sole Proprietorship Other: _____

Corporate Officers: President: _____ Secretary: _____

Does the Corporation own the Equipment? Yes No

Office Street Address: _____

City/State/Zip Code: _____

Email Address: _____ May we E-Mail you? Yes No

Office Telephone Numbers: (____) _____ - _____ (____) _____ - _____
Main Number Fax Number

(____) _____ - _____ (____) _____ - _____
Mobile Number Other:

Home Street Address: _____

City/State/Zip Code: _____

Home Telephone Numbers: (____) _____ - _____ (____) _____ - _____
Main Number Fax Number

Where would you like us to contact you (please check all that apply)?

Phone: Office Home Mobile Other: _____

Mail: Office Home Email Only Other: _____

How did you hear about ADS Florida, LLC: _____

Accountant Firm: _____

Phone: (____) ____ - _____ Email Address: _____

Attorney Firm: _____ Attorney Name: _____

Phone: (____) ____ - _____ Email Address: _____

Landlord's Name: _____

Phone: (____) ____ - _____ Email Address: _____

Dental School Alma Mater: _____ Year Graduated: _____

Post Graduate Degree: _____ Year Graduated: _____

Specialty Designations: _____

Special Training / CE (Practice Management, Clinical, etc): _____

Practice in Location: ____ years Seller in Location: ____ years Seller Owned Practice: ____ years Scratch Start Purchase

If purchased, production at purchase: \$ _____ Acquisition Price: \$ _____ Selling Doctor: _____

Beyond the transition period, how long do you plan to stay with the practice after the sale: _____ months

Do you own other practices? Yes No How far apart are the practices? _____ miles

What professional organizations do you belong to? _____

Do you have any health conditions that may impact the future viability of the practice? Yes No

Have you had any lawsuits filed against you? Yes No

Have You Been Disciplined by the State Boards? Yes No Explain: _____

Do you have an associate? Yes No Do you have a partner? Yes No

Partner Name: _____ Partner Compensation: _____% Partner Collections: \$ _____

Do you have a buy-out agreement with your partner? Yes No Restrictive Covenant? Yes No

Associate Name: _____ Associate Compensation: _____% Associate Collections: \$ _____

Do you have a written contract with your associate? Yes No Restrictive Covenant? Yes No

FACILITY

Location: Shopping Center Professional Bldg Free Standing Condo Other: _____

_____ Sq. Feet Is the office expandable: Yes No Is the office handicapped accessible? Yes No

Total Plumbed Ops: ____ Doctor Ops: ____ Hygiene Ops: ____ Handed: Right Left Either

Does your office currently meet the following guidelines? OSHA: Yes No CDC: Yes No HIPPA: Yes No

OWNERSHIP

Own For Sale Property Value: \$ _____ Real Estate Tax: \$ _____

Lease Monthly Rent: \$ _____ CAM: \$ _____ Years Remaining: _____ Options: _____

Lease Assignable? Yes No Number of Parking Spaces _____ If Owned, Total Building Sq Feet: _____

OFFICE HOURS

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

Approx. vacation days in most recent calendar year: _____ Number of available days / week: Doctor: ____ Hygiene: ____

PATIENT INFORMATION

Avg. Number of Patients/Day (Dentist): _____ Number of Active Patients (last 18 months): _____

Number of New Patients/Month: _____ Average Age of Patients: _____ Advance Scheduling: _____ wks

Population of your Town: _____ Population of the Drawing Area: _____

Sources of New Patients: ____ % Existing Patients ____ % Advertising ____ % Insurance ____ % Other: _____

Do you utilize.. Online Appointment Scheduling: Yes Email or SMS Appointment Reminders: Email SMS Both

PAYMENT TYPE

Cash: ____% Indemnity/Private Insurance: ____% PPO: ____% HMO: ____% Medicaid: ____%

Last Fee Increase: ____ / ____ / ____ Collection Pct: ____ % Accept Assignment: Yes Monthly Cap. Check: \$ _____

Reduced Fee (PPO, HMO) Companies: _____

Major Employers of your Patients: _____

ACCOUNTS RECEIVABLE

\$ _____ Current \$ _____ >30 Days \$ _____ >60 Days \$ _____ >90 Days

HYGIENE DEPARTMENT

Collections: \$ _____ Avg. Number of Patients/Day: _____ Advance Scheduling: _____ wks

Number of New Patients/Month: _____ Soft Tissue Management Program: Yes No

PERCENTAGE OF TOTAL FEES RECEIVED FROM THE FOLLOWING

_____ % Hygiene	_____ % Operative	_____ % Diagnostic	_____ % Crown/Bridge
_____ % Pediatric	_____ % Ortho	_____ % Implant Surgery	_____ % Implant Restore
_____ % Removable	_____ % Endo	_____ % Perio	_____ % Surgery
_____ % Cosmetics	_____ % TMJ	_____ % Soft Tissue Mgmt	_____ % _____

SERVICES REFERRED OUT

Endodontics: All Some None Implant Surg.: All Some None Orthodontics: All Some None
 Pediatrics: All Some None Periodontics: All Some None Surgery: All Some None

CURRENT FEE SCHEDULE

\$ _____ Adult Prophy (1110)	\$ _____ Inlay (2520)	\$ _____ 2-Surf. Post Composite (2392)
\$ _____ 2-Surface Amalgam (2150)	\$ _____ Core Buildup (2950)	\$ _____ Porcelain/Gold Crown (2750)
\$ _____ Anterior Root Canal (3310)	\$ _____ Bicuspid Root Canal (3320)	\$ _____ Porcelain Veneer (2962)

EQUIPMENT: Computers: Front Desk Operatories Paperless None Dental Software: _____

Intraoral Cam: Yes Panorex: Yes Dig X-Ray: Yes Cerec: Yes Laser: Yes Handpieces: Air Electric Fiber

Nitrous: Plumbed for In Use Other Special Equipment: _____

Avg. Age of Equip. (Years): _____ New Equipment (Last 3 Years): _____

MARKETING

Internal Marketing: _____

External Marketing: _____

Practice Websites/URLs: _____ E-Newsletter in Use

EMPLOYEE INFORMATION

First Name	Title / Position	Year Hired	Status	Days/Week	Salary / Wages	Benefits	Family
1 _____	_____	_____	<input type="checkbox"/> FT <input type="checkbox"/> PT	_____	\$ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
2 _____	_____	_____	<input type="checkbox"/> FT <input type="checkbox"/> PT	_____	\$ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
3 _____	_____	_____	<input type="checkbox"/> FT <input type="checkbox"/> PT	_____	\$ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
4 _____	_____	_____	<input type="checkbox"/> FT <input type="checkbox"/> PT	_____	\$ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
5 _____	_____	_____	<input type="checkbox"/> FT <input type="checkbox"/> PT	_____	\$ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
6 _____	_____	_____	<input type="checkbox"/> FT <input type="checkbox"/> PT	_____	\$ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

Please Briefly Describe Benefits: _____

SYSTEMS QUESTIONNAIRE

Scheduling

Is your scheduling computerized? Yes No

Does your system allow for:

- Day at a glance? Yes No
- Setting and reviewing production goals? Yes No
- Overlapping scheduling and expanded duties? Yes No
- Pre-blocking for: production, new patients, etc? Yes No
- Delayed treatment and tickler systems? Yes No
- Effective appointing strategies for emergency patients, new patients, hygiene checks? Yes No

Do you:

- Set production goals? Yes No
- Consistently review production goals? Yes No
- Consistently meet your production goals? Yes No
- Utilize overlapping scheduling and expanded duties (where applicable)? Yes No
- Pre-blocking for production, new patients, etc? Yes No
- Review delayed treatment and use a tickler system? Yes No
- Use strategies for appointing emergency patients, new patients, hygiene checks? Yes No
- Do you utilize a text message/email appointment reminder service? Yes No

Financial Systems

Do you have written, flexible internal financial guidelines? Yes No

Is there an agreed upon financial negotiating process? Yes No

Are all financial arrangements in writing? Yes No

Is there a protocol for a strong collection strategy? Yes No

Do you monitor your collections percentage and financial arrangement receivables? Yes No

Continuing Care

Would you estimate that more than 80% of your active patient base is in continuing care? Yes No

Would you estimate that your hygiene cancellation percentage less than 5%? Yes No

Do your hygienists serve as "co-pilots" to support and promote restorative dentistry out of hygiene? Yes No

Is 90% of significant treatment presented and accepted in hygiene? Yes No

Charting

Is your charting system complete with:

- Relationship information? Yes No
- Full treatment notes? Yes No
- Motivators and concerns? Yes No
- Treatment plan highlights? Yes No
- HIPPA/confidentiality documentation? Yes No

Are your charts easy to read and follow? Yes No

Staff

Does your staff have job descriptions, job expectations, training charts and policy manuals? Yes No

Do you have formal staff meetings for statistical analysis, problem-solving and training? Yes No

Do you have formal growth conferences and salary reviews? Yes No

Does your staff fully support goals you set, including daily (or other) production goals? Yes No

Miscellaneous

Have a mostly healthy/fully restored patient base? Yes No

Is new patient flow increasing? Yes No

Is there room for improvement in the practice? Yes No

OFFICE LAYOUT

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