HENRY SCHEIN®
PROFESSIONAL PRACTICE TRANSITIONS

CONFIDENTIAL VALUATION PROFILE

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

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The purpose of this packet is to gather vital statistics necessary so you and your transition specialist can determine an estimated value or price of your practice. This has been designed for you to simply "fill in the blanks." All questions asked are extremely important so please complete the profile as fully as possible. When you have completed the data-gathering process, please mail, fax or email a copy to the contact on the cover page of this packet.

Please include the following when submitting the completed profile:

____ Three (3) Years of Practice Tax Returns
Form 1120S (S-Corp), 1120 (C-Corp) or 1040 Schedule C (Sole Proprietor) with all Exhibits and Schedules

____ Three (3) Years of Financial Statements - plus current year-to-date

____ W-2s / W-3s for last Three (3) Years (including Owner and/or Family, where applicable)

____ Detailed Historical Depreciation Schedule (Listing Yearly Total of Equipment/Furnishings Currently Used)

____ Copies of any Equipment Leases

____ Copy of any Employment Agreements (Associates or Others)

____ Current Fee Schedule

____ Financial Policy

____ Office Lease

____ Insurance Program List (PPO and HMO plans, Medicaid)

____ Staff Payroll Report for Current and Last Full Year (including Owner and/or Family, where applicable)

____ Staff Benefits Details / Financial Breakout (including Owner and/or Family, where applicable)

____ Personnel Policy / Handbook / Office Manual

From Practice Management Software (Note: Please *do not* send any reports with patient names included):

____ Accounts Receivable Aging Report (current, 30, 60, 90 days past due)

____ Demographics of Patients – Summary Report (Age, Sex, Insurance and Zip Code Statistics)

____ Productivity / Production Report by ADA Code – Current Year

____ Productivity / Production Report by ADA Code – Last Year (Full)

____ Productivity / Production Report by Provider – Current Year

____ Productivity / Production Report by Provider – Last Year (Full)

Additional Financial Reports:

____ Documentation to Show Owner's Portion of Pension/Profit Sharing (for each of the previous three years)

____ Documentation to Show Owner's Portion of Medical/Disability Insurance (for each of the previous three years)

____ Documentation to Show Owner's Portion of Employment Taxes (for each of the previous three years)

____ Documentation to Show Any Owner's Expenses Paid by Practice (i.e. extra office supplies, cell phones, etc)

I understand that the information contained in this packet will be distributed to potential buyers of my practice after they have signed and submitted a confidentiality agreement. I also understand that this information may be used by financial institutions to extend credit to potential buyers of my practice. To the best of my knowledge, this information is true and correct and an accurate representation of my practice.

_____ _____ _____ /_____ /_____
Name (Print) Signature Date

Date: _____ Practice Type: General

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

Name: _____ ☐ DDS ☐ DMD
First Middle/Maiden Last

Date of Birth: _____/_____/_____ Florida Dental License Number: _____

Spouses Name: _____ Corporate Officer? ☐ Yes
First Middle/Maiden Last

Practice Legal Name: _____ ☐ PA ☐ PC ☐ INC ☐ Other: _____

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

Incorporation Year: _____ Corporation Owns the Equipment? ☐ Yes ☐ No Corp Officers Besides You/Spouse: ☐ Yes

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: _____

Have you previously offered this practice for sale? ☐ No ☐ Yes, on my own ☐ Yes, with (firm name): _____

If yes, when? _____ Has the agreement expired? ☐ Yes ☐ No When does/did the agreement expire? _____

How did you hear about our company? _____

_____

Dental School Alma Mater: _____ Year Graduated: _____

Post Graduate Degree: _____ Year Graduated: _____

Specialty Designations: _____

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

_____

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: _____

PARTNERS

Do you have a partner? ☐ Yes ☐ No Do Partners Have Equal Shares? ☐ Yes ☐ No (Explain): _____

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

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

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

Have any partner(s) left the practice in the previous two years and continued practicing in the area? ☐ Yes ☐ No

If Yes, did they have an employment agreement with a ☐ Restrictive Covenant and/or a ☐ Non-Solicitation Agreement?

If Yes, when they were in your office, how many days per week did they treat patients? _____

PRACTICE HISTORY

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 a short transition period, how long do you plan / would you like to stay with the practice after the sale: _____ months

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

Do you work in any other practices (that you do not own) ? ☐ Yes ☐ No How far apart are the practices? _____ miles

Any event occurred during the past 12 months that may have a significant impact on practice receipts/profitability? ☐ Yes ☐ No

If Yes, please explain: _____

Are you aware of any upcoming event that may have a significant impact on practice receipts/profitability? ☐ Yes ☐ No

If Yes, please explain: _____

Do you owe any money to a bank / is there a lien on? ☐ Practice Equipment ☐ Facility (under Practice Corporation)

If Yes, with what bank(s): _____

FACILITY OWNERSHIP

☐ Own ☐ For Sale Total Building Sq Feet: _____ Association Fees: _____ Real Estate Tax: $ _____

☐ Lease Monthly Rent: $_____ CAM: $_____ Included in Rent: ☐ Electricity ☐ Water ☐ Other: _____

Years Remaining: _____ Options: _____ x _____ (Years) Lease Assignable? ☐ Yes ☐ No

If Leased (and not owned by you), Landlord's Name: _____

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

LOCATION DETAILS

Location: ☐ Shopping Center ☐ Professional Bldg ☐ Free Standing ☐ Condo ☐ Conv. Residence ☐ Other: _____

The area is: ☐ Urban ☐ Suburban ☐ Rural ☐ Growing ☐ Stable ☐ Declining ☐ Affluent ☐ Blue-Collar ☐ Transient
(please check all that apply to your current practice location)

Facility located on: ☐ Two Lane St ☐ Four Lane St ☐ Six Lane St ☐ Freeway Access Rd ☐ Other: _____

How would you rate the desirability of the location: ☐ Highly Desirable ☐ Desirable ☐ Average ☐ Questionable

Are there any desirable or adverse conditions occurring within the community and/or area's economy? ☐ Yes ☐ No

If Yes, please explain: _____

Approximate number of practice(s) that you consider to be similar to yours within the immediate geographic area: _____

FACILITY DETAILS

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

The space is _____ Sq. Feet Number of Parking Spaces: _____ for Patients and _____ for Staff

Is the office expandable: ☐ Yes ☐ No Is the office handicapped accessible? ☐ Yes ☐ No

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

EQUIPMENT

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

Intraoral Camera: ☐ Yes Panorex: ☐ Yes - ☐ Dig ☐ Ceph ☐ 3-D E4D: ☐ Yes Cerec: ☐ Yes Laser: ☐ Yes CT Scan: ☐ Yes

X-Ray in Every Op: ☐ Yes Dig X-Ray: ☐ Yes Nitrous: ☐ Plumbed for ☐ In Use Handpieces: ☐ Air ☐ Electric ☐ Fiber Optic

Patient Education Software: ☐ Yes (which?): _____

Do You Lease Any Equipment? ☐ Yes ☐ No If Yes, Please List Equipment: _____

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

Other Special Equipment: _____

Cost Basis of the Practice Equipment / Assets: $ _____ ☐ Confirmed ☐ Estimated

PATIENT INFORMATION

Number of Active Patients (last 18 mos): _____ Calculated by: ☐ Estimate ☐ Hand Count ☐ Computer Report

Total Number of Patient Charts in Office: _____ Calculated by: ☐ Estimate ☐ Hand Count ☐ Computer Report

Avg. Number of Patients/Day (Dentist): _____ Average Age of Patients: _____ Advance Scheduling: _____ wks

Number of New Patients/Month: _____ Percent of Office Production Related to Pediatric Services: _____ %

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

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

Major Employers of your Patients: _____

HYGIENE DEPARTMENT

Collections (Annual): $ _____ Avg. Number of Patients / Day / Hygienist: _____ Adv Scheduling: _____ wks

Number of New Patients/Month: _____ Patient Recall Period: 3mos ____% 4mos ____% 6mos ____% Other ____%

Soft Tissue Pgm: ☐ Yes ☐ No Hygienists in the Practice: ☐ Take Radiography ☐ Are Credited for Radiography ADA Codes

Have any employed hygienist(s) left the practice in the previous two years and continued practicing in the area? ☐ Yes ☐ No

If Yes, when they were in your office, how many days per week did they treat patients? _____

OFFICE HOURS, AVAILABILITY AND VACATION

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

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

ASSOCIATES

Do you have an associate? ☐ Yes ☐ No

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

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

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

Have any employed associate(s) left the practice in the previous two years and continued practicing in the area? ☐ Yes ☐ No

If Yes, did they have an employment agreement with a ☐ Restrictive Covenant and/or a ☐ Non-Solicitation Agreement?

If Yes, when they were in your office, how many days per week did they treat patients? _____

PAYMENT TYPE

Cash: _____% Indemnity / "Out of Network" Insurance: _____% PPO: _____% HMO: _____% Medicaid: _____%

Last Fee Increase: ____ /____ / ____ Collection Pct: ____ % If HMO Provider, Monthly Cap. Check: $ _____

Reduced Fee (PPO, HMO) Companies: _____

Accept Assignment: ☐ Yes ☐ No Delta Dental Premier Participant: ☐ Yes ☐ No

Do you utilize third party payment companies (i.e. Care Credit): ☐ Yes:_____ ☐ No

Historically, the month has been the practice's most productive: _____ and least productive: _____

ACCOUNTS RECEIVABLE

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

SERVICES REFERRED OUT AND PHILOSOPHY

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

Practice philosophy emphasis: ☐ TMJ ☐ Non-Amalgam ☐ Holistic ☐ Pankey ☐ Dawson ☐ LVI ☐ Other: _____

MARKETING

Internal Marketing:_____

External Marketing: _____

Practice Websites/URLs: _____ ☐ E-Newsletter in Use

EMPLOYEE INFORMATION

	First Name	Title / Position	Year Hired	Status	Days/Week	Wage	Benefits
1	_____	_____	_____	☐ FT ☐ PT	_____	$ _____	☐ Yes ☐ No ☐ Partial
2	_____	_____	_____	☐ FT ☐ PT	_____	$ _____	☐ Yes ☐ No ☐ Partial
3	_____	_____	_____	☐ FT ☐ PT	_____	$ _____	☐ Yes ☐ No ☐ Partial
4	_____	_____	_____	☐ FT ☐ PT	_____	$ _____	☐ Yes ☐ No ☐ Partial
5	_____	_____	_____	☐ FT ☐ PT	_____	$ _____	☐ Yes ☐ No ☐ Partial
6	_____	_____	_____	☐ FT ☐ PT	_____	$ _____	☐ Yes ☐ No ☐ Partial
7	_____	_____	_____	☐ FT ☐ PT	_____	$ _____	☐ Yes ☐ No ☐ Partial

Please Briefly Describe Benefits: _____

Any Staff Also Family Members of Owner? ☐ No ☐ Yes (please list): _____

Any Staff Expected to Leave Post-Transition? ☐ No ☐ Yes (please list): _____

SYSTEMS QUESTIONNAIRE

Scheduling

Is the appointment scheduling computerized? ☐ Yes ☐ No

Does the scheduling system allow for:

- Day at a glance? ☐ Yes ☐ No
- Setting and reviewing production goals? ☐ Yes ☐ No
- Overlapped 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

Does the practice have:

- Set production goals? ☐ Yes ☐ No
- Consistently reviewed production goals? ☐ Yes ☐ No
- Consistently met production goals? ☐ Yes ☐ No
- Utilization of overlapped scheduling and expanded duties (where applicable)? ☐ Yes ☐ No
- Pre-blocking for production, new patients, etc? ☐ Yes ☐ No
- Review of delayed treatment and use a tickler system? ☐ Yes ☐ No
- Strategies for appointing emergency patients, new patients, hygiene checks? ☐ Yes ☐ No
- A text message/email appointment reminder service? ☐ Yes ☐ No

Financial Systems

Are there 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

Are the collections percentage and financial arrangement receivables monitored? ☐ Yes ☐ No

Continuing Care

What percentage of your active patient base would you estimate is in continuing care? _____%

What is the estimated hygiene cancellation percentage? _____%

What percentage of significant treatment presented in hygiene is accepted? _____%

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

Charting

Does the patient charting system include:

- 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 the charts easy to read and follow? ☐ Yes ☐ No

Staff

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

Are formal staff meetings for statistical analysis, problem-solving and training scheduled? ☐ Yes ☐ No

Are formal growth conferences and salary reviews performed? ☐ Yes ☐ No

Does the staff fully support goals practice goals, including daily (or other) production goals? ☐ Yes ☐ No

Miscellaneous

Does the practice have a mostly healthy/fully restored patient base or is there significant, dentistry remaining? (circle one)

Is new patient flow increasing? ☐ Yes ☐ No

Is there room for improvement in the practice? ☐ Yes ☐ No

If yes, briefly describe: _____

OFFICE LAYOUT

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