S.G .Reader & Associates. Inc.
Practice Management Consultants

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Practice Profile

Practice: General

1. Clinic Name:_____Dr. Name:_____

2. Office Address _____

3. City/State/Zip _____

4. Cell Phone _____ Email: _____

5. Home Phone: _____

6. E-Mail Address: _____

7. Dental School _____ Graduated _____

8. Years established_____ By owner _____

9. Gross Billing: . . . 2018_____ 2019_____2020_____

10. Gross Receipts:..2018_____2019_____2020_____

11. Overhead. . . 2018_____2019_____2020_____

NOTE: Exclude all depreciation charges and all expenditures for doctor's salary, bonus and fringe benefits (i.e. automobile, dues, and memberships, life-health-disability insurance, retirement plan contributions, etc.)

12.HMO/PPO Groups currently working with:

13. Approximate dollar amount collected from the HMO/PPO groups last year:

14. Attorneys:

15. Legal Networkers:

16. Specialized Referrals from other sources:

17. **ACCOUNTS RECEIVABLE**:

i. Present Balance: $_____

ii. Aging Schedule

Current	$_____	91-120	$_____
31-60	$_____	121-120	$_____
61-90	$_____	181 Plus	$_____

iii. Receivable Profile:

Patients Direct Pay……$_____
Private Insurance……$_____
Workman's Comp……..$_____
HMO/PPO (by carrier)……...$_____
Personal Injury……...$_____
Medicare/Medicaid……$_____
Other……..$_____

18. CLINIC NET ASSETS:……...……$_____

NOTE: Include only those assets owned or leased by the clinic. Land at cost, building net of accumulated depreciation, and furniture, fixtures, equipment, leasehold improvement and capitalized lease net of accumulated depreciation. Exclude cash, marketable securities (if any) and accounts receivable.

19. Number of Active patient charts _____

20. Average age of patients _____

21. Left Handed_____ Right Handed_____

22. Number of operatories _____

23. Office size _____sq.ft.

24. Clinic Hours _____

25. What percent of your practice is:

Fixed Prosthetics____% Operative ____% Cosmetic ____% Removable Pros ____%

Endo ____% TMJ ____% Ortho ____% Pedo ____%

Implant ____% Perio ____% Other ____% Surgery ____%

Soft Tissue Management ___% Preventive ___% Hygiene ____%

Services referred out: Endo_____% Perio_____% Surgery_____%

Pedo_____% Implant Surgery___%

26. Please Attach Fee Schedule:

27. Population of Drawing Area: _____

STATISTICAL SUMMARY 2021

Please list your practice statistics for the last 12 months

Month/Year	Collections	Services	New Patients	Total Visits
12 Month Totals				

S. G. READER & ASSOCIATES, INC. USE ONLY

COLLECTIONS RATIO	CASE AVERAGE	VISIT AVERAGE	NEW PATIENT AVERAGE	RETENTION RATIO

HMO/PPO COLLECTIONS REPORT

If you are an HMO/PPO provider, please complete the following information. If you do not have exact figures, please estimate, but be as accurate as possible. This form will be presented to qualified prospective purchasers and their advisors.

NAME OF PROVIDER	AMOUNTED COLLECTED YEAR
PHCS	
BEECH ST.	
BLUE CHOICE	
ASHN	
AMERICA WHOLE HEALTH NETWORK	
CCN	
HNA	
CIPA	
OMNI	
CHPA	
SPN	
FCA	
PHN	
IHP	
CHPS	
AETNA	
AFFORDABLE	
ANTHEM	
CAPP-CARE	
AHP	

NOTE: If any of your figures are an estimate, please place "est." after each amount.

RATE YOUR OFFICE

	Circle One				
	Poor				Excellent
How well equipped is your clinic?	**1**	**2**	**3**	**4**	**5**
Do you have enough space in your clinic?	**1**	**2**	**3**	**4**	**5**
Is your clinic easy to find?	**1**	**2**	**3**	**4**	**5**
Is your clinic on a busy street?	**1**	**2**	**3**	**4**	**5**
Is your clinic well marked?	**1**	**2**	**3**	**4**	**5**
Is your clinic visible?	**1**	**2**	**3**	**4**	**5**
Is your clinic accessible?	**1**	**2**	**3**	**4**	**5**
Does your clinic have adequate parking?	**1**	**2**	**3**	**4**	**5**

STAFF

NOTE: If your spouse, relatives, or any special people work for you, please indicate their relationship when filling out the information below.

Name_____Length of Employment_____
Monthly Pay _____Bonus Pay_____
Salary_____ Hourly _____Contract Labor_____
Special Conditions_____
General Duties_____
_____
Hours Required to Work_____
Doctors Personal Evaluation Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Name_____Length of Employment_____
Monthly Pay _____Bonus Pay_____
Salary _____Hourly _____Contract Labor_____
Special Conditions_____
General Duties_____
_____
Hours Required to Work_____
Doctors Personal Evaluation Poor 1 2 3 4 5 6 7 8 9 10 Excellent

STAFF - CONTINUED

NOTE: If your spouse, relatives, or any special people work for you, please indicate their relationship when filling out the information below.

Name_____Length of Employment_____

Name_____Length of Employment_____
Monthly Pay _____Bonus Pay_____
Salary _____Hourly _____Contract Labor_____
Special Conditions_____
General Duties_____
_____
Hours Required to Work_____
Doctors Personal Evaluation Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Name_____Length of Employment_____
Monthly Pay _____Bonus Pay_____
Salary _____Hourly _____Contract Labor_____
Special Conditions_____
General Duties_____
_____
Hours Required to Work_____
Doctors Personal Evaluation Poor 1 2 3 4 5 6 7 8 9 10 Excellent

ROOM:_____ PAGE_____OF_____

(Take as many pages as necessary to list information on all equipment, furniture and fixtures, room by room - - e.g., Operatory #1, #2, #3, #4; Hygiene room; Laboratory; Darkroom; Sterilization area; Utility room; Panoramic; Lounge; Office; Reception room; File room; etc.)

Qty	Year or Age	DESCRIPTION (Include Make, Model & Mfgr.)	Serial Number For Items over $500	Own	Lease	Original Value

DOCTOR OBSERVATION

Practice

What do you see as the strongest two areas in your practice?

A._____

Personal

What do you see as your two strongest attributes as they relate to your practice?
A._____

_____

B._____

_____

What do you see as your two weakest attributes as they relate to your practice?
A._____

_____

B._____