



# Practice Appraisal Application

## **ADS Lovelace and Associates, Inc.**

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# PRACTICE PROFILE

Please print in **BLACK INK** and return completed forms with all additional information requested.

Incomplete responses and failure to provide all information requested delays starting Appraisal

*All pages except 1 and 2 will be included in the Valuation Report.*

**\*\*\*ITEMS MARKED WITH AN ASTERISK (\*) CAN BE OBTAINED USING DENTAL PRACTICE OPTIMIZER SOFTWARE AVAILABLE FROM YOUR ADS BROKER\*\*\*\***

## GENERAL INFORMATION

Check all that apply:

**DEGREE:**

D.M.D.  Other(\_\_\_\_\_)  
 D.D.S.

**BUSINESS ORGANIZATION TYPE:**

P.C.  Inc.  C Corp  Sole Proprietor  
 P.A.  Other  S Corp  Partnership

Owner's Name: \_\_\_\_\_  
*First M.I. Last*

Date of Birth: \_\_\_\_\_

Corporate or other Practice Name: \_\_\_\_\_

Corporate: President's Name: \_\_\_\_\_

Vice-President's Name: \_\_\_\_\_

Secretary's Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ Parish/County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Website: \_\_\_\_\_

Your preferred location to direct our correspondence:  Home  Office  Email  Fax  
 Other \_\_\_\_\_

Spouse's Name: \_\_\_\_\_  
*First M.I. Last*

If Divorced, is property settlement final?  Y  N

Office Phone: \_\_\_\_\_

Office Backline: \_\_\_\_\_ Office Fax: \_\_\_\_\_ [Secure:  Y  N]

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Fax: \_\_\_\_\_ [Secure:  Y  N] Secure Email: \_\_\_\_\_

May we send confidential communications to the above secure areas?  Yes  No

Purpose of the Appraisal: \_\_\_\_\_

Estimate practice value: \_\_\_\_\_ How did you arrive at this figure? \_\_\_\_\_

Your urgency if selling the practice: \_\_\_\_\_ (Enter a number from 1 to 10. "10" represents selling in 30 days. "1" represents selling in 2 years.)

What are your plans after selling the practice? \_\_\_\_\_ Describe any health problem. \_\_\_\_\_

Which staff members are aware of this appraisal? \_\_\_\_\_

Do they know the purpose of the appraisal? \_\_\_ Yes \_\_\_ No

How did you hear about or who referred you to ADS Lovelace and Associates, Inc.? \_\_\_\_\_

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**ADDITIONAL INFORMATION REQUESTED (Copies Only – Data not Returned.)**

*Please advise us immediately if more than one practice is reported on the tax returns or financial statements.*

**Enclosed (Please check-off items provided.)**

- \_\_\_ Last three years Tax Returns. (If sole proprietor provide Form 1040 Schedule C, include statement of “**other expenses**”, if corporation provide Form 1120 or 1120S with statement of “**other expenses**”, partnerships 1065)
- \_\_\_ Practice financial statements for the last three years. (include income statement, profit and loss statement, and balance sheet)
- \_\_\_ Provide an explanation of all non-dental income and/or income from another location of the practice that appears on any Tax returns or financial statements.
- \_\_\_ Practice interim (year to date) financial statements for the periods:(beginning of tax year through \_\_\_/\_\_\_/\_\_\_)
- \_\_\_ Latest detailed Depreciation Schedule. (if not included with tax return)
- \_\_\_ Previous year’s W-2 forms, identify job description for each employee. (e.g. chairside, hygienist, front office etc.)
- \_\_\_ Current signed Office Lease with any extensions, if you do not own your office.
- \_\_\_ Employment Contracts with associates, partners, and/or employees. (including covenants not to compete)
- \_\_\_ Contracts. (telephone ads, telephone services, service and maintenance agreements, warranties, etc.)
- \_\_\_ Equipment Leases. (postage machine, credit card processor, dental equipment, office equipment,. etc.)
- \_\_\_ First page of monthly Bank Statements since the beginning of the current year.
- \_\_\_ Accounts Receivable aging Report. (30, 60, 90, and over 90 days)\*
- \_\_\_ Your current fee for service schedule and fee schedules for any reduced fee plans.
- \_\_\_ Photographs of all rooms and exterior of office. (digital photographs may be emailed to Plovelace@gmail.com)
- \_\_\_ Diagram of the office layout – may be hand drawn. (worksheet provided)
- \_\_\_ Office Equipment Inventory List. (recommended to have equipment appraisal from dealer rep., if not available complete worksheet provided)
- \_\_\_ List of items excluded from sale. (worksheet provided)
- \_\_\_ Lien Holder(s) Note(s) – Loans secured by practice assets.
- \_\_\_ Appraisal Fee of \$2,500

**(All information requested must be supplied and completed before appraisal is started)**

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**PROFESSIONAL ADVISORS**

**ACCOUNTING FIRM:** \_\_\_\_\_

Your Accountant’s Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**LAW FIRM:** \_\_\_\_\_

Your Attorney’s Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**CONSULTING FIRM:** \_\_\_\_\_

Your Consultant’s Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**LANDLORD'S OR LEASING COMPANY'S NAME:** \_\_\_\_\_

Your Leasing Agent's Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

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***PERSONAL DEBT***

<b>To</b>	<b>Original Amount of Note</b>	<b>Balance as of Date _____</b>	<b>Monthly Payment</b>	<b>Date Note Began</b>	<b>Length of Note</b>	<b>Interest Rate</b>

\* Please include copies of each Note.

**ALL INFORMATION BEYOND THIS POINT WILL BE INCLUDED IN THE VALUATION REPORT  
AND PROVIDED TO PROSPECTIVE BUYERS**

## EDUCATION INFORMATION

	Institution	Degree	Date Completed
Undergraduate	_____	_____	_____
Dental School	_____	_____	_____
Graduate School/Residency	_____	_____	_____
Specialty Training	_____	_____	_____

Board Qualified:  Yes  No      Board Certified:  Yes  No

What Professional Organizations do you belong to?  ADA  State  Local(\_\_\_\_\_)  Study Group(\_\_\_\_\_)

How many hours of Continuing Education have you completed in the last 24 months? \_\_\_\_\_ Hours

What courses? \_\_\_\_\_

## PRACTICE HISTORY

Year began practice in present city: \_\_\_\_\_ Year began practice in present location: \_\_\_\_\_

	<u>Former Owner</u>	<u>Current Status of Former Owner</u>
Did you Purchase your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No When _____	_____	_____
Practice gross in acquisition year: _____		
Did you Start your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No When _____		
Do you practice in Another Office? <input type="checkbox"/> Yes <input type="checkbox"/> No Where _____		
If yes, is it within the subject practice drawing area? <input type="checkbox"/> Yes <input type="checkbox"/> No		
YES NO N/A		
____ Are you incorporated?		
____ Does your corporation own the equipment? Describe: _____		
____ Do you have a partner? Name: _____ Start Date: _____		
o Do you have a contract with your partner?		
o Do you have a buy-out agreement with your partner?		
o Is there a restrictive covenant?		
____ Do you have an associate? Name: _____ Start Date: _____ Compensation		
o Do you have a contract with your associate? Formula: _____		
o Do you have a buy-out agreement with your associate?		
o Is there a restrictive covenant?		
____ Have you had a partner or associate leave within the last 3 years? Explain: _____		
____ Do you share space with another dentist? If yes, please describe the arrangement and include a copy of the agreement. _____		

## FACILITY

Do you Own or Lease your office?  OWN  LEASE

Size of the office: \_\_\_\_\_ Sq. Ft.      Expandable: \_\_\_\_\_ Sq. Ft.

Parking: Number of Spaces# \_\_\_\_\_ Proximity of Parking:  Adjacent  Parking Garage  Free  Charge(\$ \_\_\_\_\_)

Is the office Handicapped Accessible?  Yes  No

Number of Treatment Rooms: Doctor # \_\_\_\_\_ Hygiene # \_\_\_\_\_ Additional Rooms: Plumbed # \_\_\_\_\_ Not Plumbed # \_\_\_\_\_

Treatment Rooms set up for: Right-Handed Delivery \_\_\_\_\_ Left-Handed Delivery \_\_\_\_\_ Interchangeable \_\_\_\_\_

Is Office equipment owned Individually or by the Corporation? \_\_\_\_\_

Has Equipment been appraised?  Y  N Date of Appraisal: \_\_\_\_\_ By Whom \_\_\_\_\_ Value: \_\_\_\_\_

**FOR LESSEES:**

Date Lease Entered: \_\_\_\_\_ Date Lease Expires: \_\_\_\_\_

Options to Renew:  Yes  No Length of Option Term: \_\_\_\_\_ Yrs. Lease Rate for Option Renewal: \$ \_\_\_\_\_

Current Total Monthly Rent: \$ \_\_\_\_\_ When does Rent increase? \_\_\_/20\_\_\_ What is New Monthly Rent: \$ \_\_\_\_\_

What is included in the Monthly Rent?  Water  Electrical  Gas  Janitorial  Property Taxes  
 Building Insurance  Security  Common Area Maintenance  Parking

Other Services Paid for Separately (Not Included in Rent): Describe \_\_\_\_\_

Is the Lease Transferable pursuant to its terms?  Yes  No

**FOR OWNERS OF OFFICE REAL ESTATE:**

Do you wish to sell the Real Estate?  Yes  No Sale Price: \$ \_\_\_\_\_

Current Annual Real Estate Taxes: \$ \_\_\_\_\_

Current Annual Real Estate Insurance: \$ \_\_\_\_\_

Average Annual Real Estate Maintenance Costs: \$ \_\_\_\_\_

Are the above Real Estate Costs paid directly by:  Practice  Personally  Company owned by Dentist

Is there a current Real Estate Appraisal?  Yes  No

Date of Appraisal: \_\_\_\_\_ Appraised Value: \$ \_\_\_\_\_

**IF NOT SELLING REAL ESTATE:**

Rental Term in years: \_\_\_\_\_ years Monthly Rental: \$ \_\_\_\_\_

What is included in the Monthly Rent?  Water  Electrical  Gas  Janitorial  Property Taxes  
 Building Insurance  Security  Common Area Maintenance  Parking

Will you Lease with Option to Purchase?  Yes  No Describe: \_\_\_\_\_

Will you owner finance?  Yes  No Terms for Owner Financing: \_\_\_\_\_

**PRACTICE INFORMATION**

You currently work \_\_\_\_\_ days per week.\*

Number of Vacation + Holidays + CE days / year? \_\_\_\_\_

You currently work \_\_\_\_\_ weeks per year.\*

How many days per week do you plan on working in the practice after the sale?

If merging with another practice, how many days per week do you plan on working in the practice after the merger?

- Year 1 \_\_\_\_\_ days/week
- Year 2 \_\_\_\_\_ days/week
- Year 3 \_\_\_\_\_ days/week
- Year 4 \_\_\_\_\_ days/week
- Year 5 \_\_\_\_\_ days/week
- Year 6 \_\_\_\_\_ days/week
- Year 7 \_\_\_\_\_ days/week

- Year 1 \_\_\_\_\_ days/week
- Year 2 \_\_\_\_\_ days/week
- Year 3 \_\_\_\_\_ days/week
- Year 4 \_\_\_\_\_ days/week
- Year 5 \_\_\_\_\_ days/week
- Year 6 \_\_\_\_\_ days/week
- Year 7 \_\_\_\_\_ days/week

What practice consultants have you used in the past 5 years? \_\_\_\_\_  
When? \_\_\_\_\_

What were the results? \_\_\_\_\_  
\_\_\_\_\_

Describe any internal marketing used: \_\_\_\_\_

Describe any external marketing used: \_\_\_\_\_

Number of Patients on Active Hygiene Recall: \_\_\_\_\_\*

Number of Active Patients (Patients seen in last 18 months): \_\_\_\_\_\*

How did you calculate Patient count: \_\_\_ Computer Count \_\_\_ Actual Manual Count

Is Appointment Book kept on: \_\_\_ Computer \_\_\_ Manually.

Number of New Patients seen per month over the last year \*: \_\_\_Jan \_\_\_Feb \_\_\_Mar \_\_\_Apr \_\_\_May \_\_\_June  
\_\_\_July \_\_\_Aug \_\_\_Sept \_\_\_Oct \_\_\_Nov \_\_\_Dec

Average # New Patients per Month\*: \_\_\_\_\_ Average # of cancellations per Day: \_\_\_\_\_

Average # Patients seen per day – Dentist\*: \_\_\_\_\_ Average # Patients seen per day – Hygienist: \_\_\_\_\_

How far ahead are you booked? Dentist: \_\_\_weeks Hygienist: \_\_\_weeks Average # of Hygiene Days per week: \_\_\_\_\_

What percentage of practice income is from? \*

Fee For Service \_\_\_\_\_%(What % FFS is: Cash \_\_\_\_\_%,Credit Card \_\_\_\_\_%, Indemnity Ins. \_\_\_\_\_% Financed \_\_\_\_\_%)

HMO \_\_\_\_\_% PPO \_\_\_\_\_% Capitation \_\_\_\_\_% Medicaid \_\_\_\_\_% Other Reduced Fee Plans \_\_\_\_\_%

Monthly Payment from Capitation Plans: \$ \_\_\_\_\_ What PPO Plans \_\_\_\_\_

What PPO Plans cancelled & when? \_\_\_\_\_

The Office is staffed during these Hours:

M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ Th \_\_\_\_\_ F \_\_\_\_\_ S \_\_\_\_\_

Patients are seen in the Office during these Hours:

M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ Th \_\_\_\_\_ F \_\_\_\_\_ S \_\_\_\_\_

Doctor's Hours in the Office:

M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ Th \_\_\_\_\_ F \_\_\_\_\_ S \_\_\_\_\_

Hygiene Hours in the Office:

M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ Th \_\_\_\_\_ F \_\_\_\_\_ S \_\_\_\_\_

What is balance of Accounts Receivable?\* \$ \_\_\_\_\_ What is your Collection Ratio? \_\_\_\_\_

What type of Recall System is in use? \_\_\_\_\_

What type of Computer System and Software is in the office?\* \_\_\_\_\_

Is Software Assignable? \_\_\_ Yes \_\_\_ No

Is there a Fee for Assignment? \_\_\_ Yes \_\_\_ No How much is Transfer Fee: \$ \_\_\_\_\_

**Provide Computer Print-out of Production by Procedure Report by Major Classifications (Procedures designated by ADA Code), otherwise estimate what percentage of your practice is: \***

Preventative/Hygiene/Diagnostic	_____%	Operative	_____%
Pedodontics	_____%	Orthodontics	_____%
Implants	_____%	Removable Pros.	_____%
Fixed Pros.	_____%	Endodontics	_____%
Periodontics	_____%	Oral Surgery	_____%
Cosmetic	_____%	TMJ Treatment	_____%
Soft Tissue Management	_____%	Other _____	_____%

**TOTAL 100%**

What procedures do you refer out? \_\_\_\_\_

**FEE SCHEDULE: \***

Adult Prophy **01110** \$ \_\_\_\_\_ Gold Inlay **02540** \$ \_\_\_\_\_ Anterior Composite **02331** \$ \_\_\_\_\_

Two Surface Posterior Composite **02386** \$ \_\_\_\_\_ Cast Framework - Partial Denture **D5213** \$ \_\_\_\_\_

Two Surface Amalgam **02150** \$ \_\_\_\_\_ Core Build-Up Including Pins **02950** \$ \_\_\_\_\_

Gold/Porcelain Crown **02750** \$ \_\_\_\_\_ Anterior Canal Root Canal **03310** \$ \_\_\_\_\_

Bicuspid Root Canal **03320** \$ \_\_\_\_\_ Labial Porcelain Veneer **02962** \$ \_\_\_\_\_

When was the last fee increase? \_\_\_\_\_ What percentage was the last fee increase? \_\_\_\_\_%

Are the fees low, average, or high compared to other practices in your area?\* \_\_\_ Low \_\_\_ Average \_\_\_ High

At what percentile are your fees compared to other practices in your area?\* \_\_\_\_\_% Not Sure \_\_\_\_\_.

**DEMOGRAPHIC AREA:**

Population of City/Town \_\_\_\_\_ Population of Drawing Area \_\_\_\_\_

Number of Dentists within 5 Mile Radius \_\_\_\_\_ Number of New Dentists in 5 Miles Radius in Last 5 Years \_\_\_\_\_

Major Employers in Area: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any Major Economic Changes in Drawing Area: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any other Demographic Information that may be helpful: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PATIENT PROFILE: \***

<u>SocioEconomic</u>		<u>Age</u>		<u>Zip Code(Six Largest Patient Zips)</u>	
Upper	_____ %	Under 20 Years Old	_____ %	Zip Code # _____	1 <sup>st</sup> _____ %
Upper Middle	_____ %	21 - 30 Years Old	_____ %	Zip Code # _____	2 <sup>nd</sup> _____ %
Middle	_____ %	31 - 40 Years Old	_____ %	Zip Code # _____	3 <sup>rd</sup> _____ %
Lower Middle	_____ %	41 - 50 Years Old	_____ %	Zip Code # _____	4 <sup>th</sup> _____ %
Low	_____ %	51 - 60 Years Old	_____ %	Zip Code # _____	5 <sup>th</sup> _____ %
Poverty	_____ %	61 + Years Old	_____ %	Zip Code # _____	6 <sup>th</sup> _____ %
<b>Total</b>	<b>100%</b>	<b>Total</b>	<b>100%</b>		

## STAFF INFORMATION

Please list the following information by Position:

Position	Name	*Gross Annual Salary or Commission	Commission Rate, if Commissioned	Benefits (pension, health, etc.)	Full-Time / Part-Time	Year Hired	Will Stay After Sale	Is there a Signed Contract?
Office Manager								
Receptionist								
Bookkeeper								
Assistant 1								
Assistant 2								
Assistant 3								
Assistant 4								
Hygienist 1								
Hygienist 2								
Hygienist 3								
Lab Technician								
Associate								
Associate								
Other								

*\*Wages plus Incentives and Bonuses*

What employee fringe benefits are provided: Retirement Plan  Yes  No Amount Contributed \$ \_\_\_\_\_  
 Health Insurance  Yes  No Amount Contributed \$ \_\_\_\_\_ Other Benefits \_\_\_\_\_

Do you employ family members?  Yes  No Are they paid?  Yes  No

Please give job descriptions for family members \_\_\_\_\_

Describe any unpaid family member employees, their position, schedule, duties: \_\_\_\_\_

Does any Position pay more than market value?  Y  N If Yes, how much? \_\_\_\_\_

Does your office currently meet all OSHA & CDC guidelines?  Yes  No

If No, explain \_\_\_\_\_

Does your office comply with provisions of your state dental practice act?  Yes  No

If No, explain \_\_\_\_\_

Have you received any disciplinary actions in the past seven years?  Yes  No

If Yes, explain \_\_\_\_\_

Have you had any suits filed against you in the past ten years?  Yes  No

If Yes, explain \_\_\_\_\_

Please describe any other information that would be helpful in selling your practice. Include a description of your patients and practice philosophy. (If you need additional space, use back of this page.) \_\_\_\_\_

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## ADDITIONAL PRACTICE INFORMATION

### 1. Computer Information:

Do you use:

- a. Electronic insurance filing?  Yes  No
- b. Send statements daily?  Yes  No Monthly?  Yes  No
- c. Insurance tracking?  Yes  No
- d. Treatment pending reports?  Yes  No
- e. Recall as part of the program?  Yes  No
- f. Computer scheduling?  Yes  No
- g. Computer maintenance agreement?  Yes  No

How much is paid annually for computer maintenance agreement? \$ \_\_\_\_\_

2. Do you use an outside collection agency?  Yes  No What agency? \_\_\_\_\_

If so, what is the arrangement? \_\_\_\_\_

3. Do you see all emergencies the same day?  Yes  No
4. Do you currently hold staff meetings?  Yes  No Who conducts?  Dr.  Off Mgr.  Consultant

If so, how often?  Daily  Weekly  Monthly

5. Who schedules Operative? \_\_\_\_\_ Who schedules Hygiene? \_\_\_\_\_

6. How and when are appointments confirmed: \_\_\_\_\_

7. Do you have a Staff Training Manual?  Yes  No

8. Do you keep employee files?  Yes  No

### 9. Technology: Do you have any of the following?

- a. Computers in the treatment rooms?  Yes  No
- b. Intra oral cameras?  Yes  No
- c. Digital radiography?  Yes  No
- d. Imaging software?  Yes  No
- e. Patient charts digitally recorded(paperless)  Yes  No
- e. Air abrasion system?  Yes  No
- f. Cameras (other)  Yes  No
- g. X-Ray units in each room  Yes  No

10. Do you have a current Employee Handbook or Personnel Policy Manual?  Yes  No

11. Do you perform lab functions in the office?  Yes  No What lab do you use? \_\_\_\_\_

12. Describe any community/civic involvement. \_\_\_\_\_

13. Lists Hobbies and special interests: \_\_\_\_\_

14. Are bonuses used as compensation in the practice?  Yes  No Explain Bonus plan: \_\_\_\_\_

15. Do you have a communicator system in the office?  Yes  No If so, what kind? \_\_\_\_\_

## PRACTICE FINANCIAL DATA

### *DEBT AGAINST PRACTICE*

To	Original Amount of Note	Balance as of Date _____	Monthly Payment	Date Note Began	Length of Note	Interest Rate

\* Please include copies of each Note.

### *PRODUCTION \**

	YTD 1/1/____ To ____/____/____	Year _____	Year _____	Year _____
Doctors Production				
Hygiene Production				
Associate Production				
Total Practice Production				

Has the practice gross collections changed significantly in the last three years?  YES  NO

If Yes, explain \_\_\_\_\_  
\_\_\_\_\_

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*I acknowledge and agree that the information provided in this form is intended to be and will be disclosed to persons (including corporations, partnerships, firms and other individuals) for the purposes contemplated and that ADS Lovelace and Associates, Inc. shall have no liability for any claims, demands or actions arising in connection herewith.*

*All income listed is dental income generated from this practice location during the time periods stated in the attached reports, unless otherwise specified.*

*To the best of my knowledge, all of the information I have provided is accurate and correct.*

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*Please Print Your Name*

*Signature*

*Date*

**Your Signature is required to process and complete this appraisal.**

# OFFICE INVENTORY LIST

**PLEASE PRINT**

**PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.**

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
<b>RECEPTION:</b>				
Waiting Room Chairs				
Waiting Room Tables				
Waiting Room Lamps				
Pictures/Decorations				
Other				
Other				
Other				
<b>BUSINESS OFFICE:</b>				
Business Office Desk				
Business Office Chair				
Copy Machine				
File Cabinets				
Typewriter				
Computer				
Printer				
Software				
Telephone System				
Cred. Card Authorization				
Other				
Other				
<b>PRIVATE OFFICE:</b>				
Desk				
Chair				
Book Case				
Telephone				
Other				
Other				
<b>MECHANICAL:</b>				
Compressor				
Vacuum Pump				
Air Dryer				
Other				
Other				
<b>LOUNGE:</b>				
Refrigerator				
Table & Chairs				
Microwave				
Other				

# OFFICE INVENTORY LIST – Cont'd

**PLEASE PRINT**

**PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.**

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
<b>X-RAY EQUIPMENT:</b>				
Panoramic X-Ray				
Film Processor				
Developing Tank				
Duplicator				
Other				
Other				
<b>TANKS:</b>				
Nitrous Manifold				
System				
Tank Valves				
Other				
Other				
Other				
Other				
<b>LAB:</b>				
Model Trimmer				
Lathe				
Furnace				
Splash Hood w/Shield				
Vibrator				
Casting Machine				
Vacuum Forming Unit				
Porcelain & Opaque Unit				
Powder Mixer				
Articulators				
Surveyor				
Plaster Bins				
Vacuum Pump				
Lab Handpieces				
Other				
Other				
Other				
Other				
<b>STERILIZATION:</b>				
Auto Clave				
Ultrasonic Cleaner				
Other				
Other				
Other				

# OFFICE INVENTORY LIST – Cont'd

**PLEASE PRINT**

**PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.**

*If you have additional Treatment Rooms or Hygiene Rooms, you may duplicate the appropriate sheet in order to include a complete listing.*

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
TREATMENT ROOM 1:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Other				
Other				
TREATMENT ROOM 2:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Other				
Other				

# OFFICE INVENTORY LIST – Cont'd

**PLEASE PRINT**

**PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.**

*If you have additional Treatment Rooms or Hygiene Rooms, you may duplicate the appropriate sheet in order to include a complete listing.*

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
TREATMENT ROOM 3:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Other				
Other				
TREATMENT ROOM 4:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Other				
Other				

# OFFICE INVENTORY LIST – Cont'd

**PLEASE PRINT**

**PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.**

*If you have additional Treatment Rooms or Hygiene Rooms, you may duplicate the appropriate sheet in order to include a complete listing.*

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
<b>HYGIENE ROOM 1:</b>				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				
<b>HYGIENE ROOM 2:</b>				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				

# OFFICE INVENTORY LIST – Cont'd

**PLEASE PRINT**

**PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.**

*If you have additional Treatment Rooms or Hygiene Rooms, you may duplicate the appropriate sheet in order to include a complete listing.*

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
<b>HYGIENE ROOM 3:</b>				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				
<b>HYGIENE ROOM 4:</b>				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				

# EXCLUDED ITEMS LIST

Please list all items that will be excluded from the sale.

#	DESCRIPTION OF ITEM
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

**Please Sketch or Attach an Office Layout:**

# ADS LOVELACE AND ASSOCIATES, INC.

## RELEASE FORM

I have engaged the services of ADS Lovelace and Associates, Inc. to prepare a valuation of my dental practice. It may be necessary for Gretchen Lovelace, M.S., CPM, CFP, Preston Lovelace, J.D., M.S. or one of their representatives to contact you for accounting and tax information that is needed in the preparation of the valuation.

Please consider this letter authorization for release of my information by

\_\_\_\_\_ to ADS Lovelace and  
*(Accounting Firm)*

Associates, Inc., and its representatives.

\_\_\_\_\_  
Name Signed

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Date

## Specialty Practice Supplement for Orthodontic and Oral Surgery

### Orthodontic Specialty Practice

Total number of patients in treatment \_\_\_\_\_ Complete banding treatment patients \_\_\_\_\_  
Partial banding treatment patients \_\_\_\_\_  
Current account balance (contracts receivable) \_\_\_\_\_  
Accounts receivable balance (money past due) \$ \_\_\_\_\_  
Number of patients in treatment no longer paying fees \_\_\_\_\_  
Cost of average full treatment: Child \_\_\_\_\_ Adult \_\_\_\_\_  
New starts this year as of Jan. 1, \_\_\_\_\_ New starts in last twelve (12) months \_\_\_\_\_  
Average down payment for records \_\_\_\_\_ Banding \_\_\_\_\_  
Average fee per visit \_\_\_\_\_ Number of patients treated at no charge \_\_\_\_\_  
Number of patients in retention \_\_\_\_\_  
Average fee per retention: Initial \$ \_\_\_\_\_ Periodic \$ \_\_\_\_\_  
Number of patients in partial treatment: Adult \_\_\_\_\_ Child \_\_\_\_\_  
Average fee for partial treatment: Adult \$ \_\_\_\_\_ Child \$ \_\_\_\_\_  
Number of patients in TMJ treatment: Adult \_\_\_\_\_ Child \_\_\_\_\_  
Average fee for TMJ treatment: Adult \$ \_\_\_\_\_ Child \$ \_\_\_\_\_  
Do you use: Begg \_\_\_\_\_% Edgewise \_\_\_\_\_% Other \_\_\_\_\_% Describe \_\_\_\_\_  
Describe technique, banding, etc. most commonly used: \_\_\_\_\_  
What percent of practice is referred from: Other dentists \_\_\_\_\_% By patients \_\_\_\_\_%  
Any other information that would be helpful in describing your practice \_\_\_\_\_

### Oral Surgery Specialty Practice

What Percent of practice is: Exodontia \_\_\_\_\_% Maxillofacial \_\_\_\_\_% TMJ \_\_\_\_\_% Trauma \_\_\_\_\_%  
Other \_\_\_\_\_% Describe \_\_\_\_\_  
Describe typical anesthesia technique for in-office surgery: \_\_\_\_\_

At what hospitals do you have privileges? \_\_\_\_\_

Have hospital privileges ever been suspended or revoked? \_\_Y\_\_N If yes, explain: \_\_\_\_\_

Describe your referral sources (number, ages, etc.) If possible, please print a list of referral sources from practice management software. \_\_\_\_\_

Any other information that would be helpful in describing your practice \_\_\_\_\_

### Periodontal Specialty Practice

Number of Patients on Recall: \_\_\_\_\_  
Do you use a periodontal laser? \_\_Y\_\_N If yes, Brand/model: \_\_\_\_\_  
Is the sale of the laser restricted by contract with its manufacturer? \_\_Y\_\_N  
Are full mouth surgeries usually performed in one visit or split into two? \_\_\_\_\_  
Are Valium, triazolam, or IV sedation used in the practice? Explain: \_\_\_\_\_