

Practice Appraisal Application

ADS Lovelace and Associates, Inc.

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Practice Transitions Made Perfect

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Practice Appraisal Application

Owner Personal Information

Date of Preparation _____ Reason for Appraisal _____

First Name _____ Middle Name _____ Last Name _____

Degree DDS _____ DMD _____ Other _____ Date of Birth _____ Spouse's Name _____

Practice Trade Name _____

Corporation Suffix PC _____ PA _____ APDC _____ LLC _____ LLP _____ Other _____

Is Corporation a "C" or a "S" Corporation? C _____ S _____

Who is the Corporation President? _____ Secretary _____

Practice Street Address _____

City _____ State _____ Zip _____

County/Parish _____

E-mail Address _____ Can we send private e-mail to you? _____

Practice Phone Number _____ Practice Fax Number _____

Can we send private information to this number? _____

Pager Number _____ Home Phone Number _____

Home Street Address _____

City _____ State _____ Zip _____

Accountant Information:

Accountant Name _____

Accountant Street Address _____

City _____ State _____ Zip _____

Accountant E-Mail _____ Phone _____ Fax _____

Attorney Information:

Attorney Name _____

Attorney Firm Name _____

Attorney Street Address _____

City _____ State _____ Zip Code _____

Attorney E-Mail _____ Attorney Phone _____ Attorney Fax _____

Leasing Information:

Leasing Company _____

Leasing Agent Name _____

Leasing Agent Street Address _____

City _____ State _____ Zip _____

Leasing Agent Phone _____ Leasing Agent Fax _____

How did you hear about ADS Lovelace and Associates, Inc.?

List of Items Required

_____ Last three years Schedule C from personal tax returns or if you are a corporation, U.S. Tax Return Form 1120 or 1120S. **Include Schedule 1 and Balance Sheet for above plus all supporting statements of "other" expenses.**

_____ Year-to-date accounting statements (profit and loss) for the latest period of the current year.

_____ Complete list of all major items to be included in the sale and date of acquisition of major items. (Use list on last page.)

_____ A copy of your office lease.

_____ Appraisal fee of \$2,500

_____ First page of bank statements since beginning of current year.

_____ Copies of any equipment leases.

_____ Copy of your current fee schedule and fee schedule for any plans.

_____ Copy of contracts with any associates, partners, or employees.

_____ Previous year's W-2 forms for employees.

_____ Photographs of all rooms and exterior of office.

_____ A diagram of the office layout -- may be hand drawn.

_____ Have Chamber of Commerce mail PPC a newcomer pack.

_____ Dentist section of your local Yellow Pages.

Circle your urgency in selling practice. ("10" represents selling in 30 days. "1" represents selling in 2 years.)

1 2 3 4 5 6 7 8 9 10

Personal Data

Dental School Alma Mater _____

Year Graduated _____

Year Beginning Practice in City _____ Year Beginning Practice in Location _____

Right or Left Handed _____ Purchase or Scratch Start _____

Professional Organizations _____

Post Graduate Degree _____

Date Completed _____

Alma Mater _____

Specialty or Designations _____

Do you have an associate? _____ Do you share space? _____

Do you have a partner? _____ Is there a written agreement? _____

Is there a buy-out agreement? _____ Is there a restrictive covenant? _____

Office Data

Office Sq. Footage _____ Expandable Footage _____

Current Monthly Rental Amount _____ Is Office Handicapped Accessible? _____

Number of Parking Spaces _____ Proximity of Parking _____

Number of Operatories Equipped for Dentist ____ Number of Operatories Equipped for Hygienist ____

Number of Plumbed But Unequipped Operatories ____ Number of Unplumbed Empty Operatories ____

If you do not own your office, provide: Date of Lease _____ Date Lease Ends _____

Term in Years _____ Years Remaining on Lease _____ Renewal Options _____

Do you own your office? _____ Do you want to sell the building? _____

What price? _____ If Not for Sale, Monthly Rental Amount _____

Annual Taxes _____ Annual Insurance _____

Post-Sale Information

Plans after Sale of Practice _____

Days/Week Currently Worked _____

Enter Desired Days Worked for New Buyer Sale

Desired Work Days/Week 1st Year

Desired Work Days/Week 2nd Year _____

Desired Work Days/Week 3rd Year _____

Desired Work Days/Week 4th Year _____

Desired Work Days/Week 5th Year _____

Desired Work Days/Week 6th Year _____

Enter Desired Days Worked for Merger Sale

Desired Work Days/Week 1st Year _____

Desired Work Days/Week 2nd Year _____

Desired Work Days/Week 3rd Year _____

Desired Work Days/Week 4th Year _____

Desired Work Days/Week 5th Year _____

Desired Work Days/Week 6th Year _____

Practice Data

Have you used a consultant in the past five years?

Who? _____

Results _____

Describe any internal marketing _____

Has your practice gross changed significantly? _____

Why? _____

Number of active patients (different patients in last 18 months) _____

If accurate number is not known. measure number of patient records in 3 feet of records, divide by 3 and multiply by number of feet of records.

Avg number new patients per month _____

Avg number patients / day by dentist _____

Avg number patients / day by hygienist _____

How far ahead is dentist scheduled? _____

How far ahead is hygienist scheduled? _____

Practice Data

% Practice Income from Cash _____

% of Patients Paying Cash _____

% of Practice Income from Insurance _____

% of Patients with Insurance _____

% of Practice Income from HMO _____

% of Patients with HMO _____

% Practice Income from PPO _____

% of Patients with PPO _____

% Practice Income from Capitation _____

% of Patients with Capitation _____

% of Practice Income from Medicaid _____

% of Patients with Medicaid _____

% of Practice Income with Reduced Fee Plan__ _____

% of Patients with with Reduced Fee Plans _____

Office Hours:

Monday _____ to _____

Tuesday _____ to _____

Wednesday _____ to _____

Thursday _____ to _____

Friday _____ to _____

Saturday _____ to _____

Scheduling Data:

DDS Hours Worked/Week _____

Hygiene Hours Worked/Week _____

Associate Hours Worked/Week _____

Dentist Patient Visits Per Year _____

Hygiene Patient Visits Per Year _____

Number of Days Worked Per Year _____

Number of Weeks Worked Per Year _____

Actual Accounts Receivable Balance _____

What is Your Collection Percentage? _____

What Type Recall System? _____

What Type Computer System? _____

What % of the Practice Income is:

Hygienist Production _____

Operative _____

Pedodontics _____

Orthodontics _____

Implants _____

Removable _____

Prosthetics _____

Fixed Prosthetics _____

Endodontics _____

Periodontics _____

Oral Surgery _____

Cosmetic _____

TMJ Treatment _____

Soft Tissue Management _____

Other _____

TOTAL (the above should total) 100%

Fee Schedule

Adult Prophy 01110	\$
Gold Inlay 02540	\$
Two Surface Posterior Composite 02386	\$
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	\$

Demographic Data

What is the approximate population of your city or town? _____

What is the approximate population of your drawing area? _____

Number of dentists within 5 miles _____

Number of new dentists within 5 miles in the last 5 years? _____

Major employers in the area

Describe any major economic changes in your drawing area

Staff Data

Describe Staff By Position As To	Annual Salary	Will Possibly Stay?	Year Hired
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Receptionist	_____	_____	_____
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Office Manager	_____	_____	_____
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Bookkeeper

Assistant

Assistant

Assistant

Assistant

Assistant

Hygienist

Hygienist

Hygienist

Hygienist

Lab Technician

Lab Technician

Other

Other

Describe Fringe Benefits and Value _____

Do You Hire Any Unpaid Family? _____ Who? _____ Describe Duties _____

Estimated Annual Value of Above _____

Production Centers

Year to Date

Last Year

Two Years Ago

_____ to _____

Gross Production

Hygienists

Owner

Associate

Associate

Associate

How is associate compensated? Amount?

Salary _____ Commission _____

How is hygienists compensated? Amount?

Salary _____ Commission _____

Practice Conformity Data

Does practice meet OSHA standards? Why not?

Does practice meet CDC guidelines? Why Not?

Does practice conform with all governmental requirements? Why not?

Have you received any disciplinary actions in the past seven years? Explain

Have you had any practice-related lawsuits filed against you in the past ten years? Explain

Describe any health problems which would affect practice of dentistry. _____

Describe your practice, staff, patients, community and practice philosophy _____

Specialty Practice Supplement for Orthodontic and Oral Surgery

Orthodontic Specialty Practice

Total number of patients in treatment _____

Complete banding treatment patient's _____ Partial banding treatment patients _____

Patients in retention _____ Patients in TMJ treatment _____

Current account balance _____ 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 Practice What percent of practice is: Exodontia _____ % Maxillofacial _____ % TMJ Specialty

Trauma _____ % Other _____ °A, Describe _____

Describe typical anesthesia technique for in-office surgery:

At what hospitals do you have privileges?

Describe your referral sources (number, ages, etc.)

Any other information that would be helpful in describing your practice