Practice Appraisal Application

ADS Lovelace and Associates, Inc.

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Baton Rouge, Louisiana 70806

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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.?__________________________

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)

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:________________________________

PERSONAL DEBT

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.

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: __________

Did you Purchase your practice? __ Yes __ No When __________ Former Owner: _______________ Current Status of Former Owner: _______________

Practice gross in acquisition year:_________________

Did you Start your practice? __ Yes __ No When __________

Do you practice in Another Office? __ Yes __ No Where __________

If yes, is it within the subject practice drawing area? __ Yes __ No

YES	NO	N/A	
__	__	__	Are you incorporated?
__	__	__	Does your corporation own the equipment? Describe: ______________________
__	__	__	Do you have a partner? Name: _________________ Start Date: __________
__	__	__	○ Do you have a contract with your partner?
__	__	__	○ Do you have a buy-out agreement with your partner?
__	__	__	○ Is there a restrictive covenant?
__	__	__	Do you have an associate? Name: _________________ Start Date: __________ Compensation Formula: __________
__	__	__	○ Do you have a contract with your associate?
__	__	__	○ Do you have a buy-out agreement with your associate?
__	__	__	○ 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?

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

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

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 *<u>Production by Procedure Report by Major Classifications</u>* (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: *

SocioEconomic		Age		Zip Code(Six Largest Patient Zips)	
Upper	______%	Under 20 Years Old	______%	Zip Code #___________	1st_______%
Upper Middle	______%	21 - 30 Years Old	______%	Zip Code #___________	2nd_______%
Middle	______%	31 - 40 Years Old	______%	Zip Code #___________	3rd_______%
Lower Middle	______%	41 - 50 Years Old	______%	Zip Code #__________	4th_______%
Low	______%	51 - 60 Years Old	______%	Zip Code #__________	5th_______%
Poverty	______%	61 + Years Old	______%	Zip Code #__________	6th_______%
Total	**100%**	**Total**	**100%**		

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.) ______________________

____

____

____

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 ____

____

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.

______________________	______________________	__________
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
RECEPTION: Waiting Room Chairs				
Waiting Room Tables				
Waiting Room Lamps				
Pictures/Decorations				
Other				
Other				
Other				
BUSINESS OFFICE: Business Office Desk				
Business Office Chair				
Copy Machine				
File Cabinets				
Typewriter				
Computer				
Printer				
Software				
Telephone System				
Cred. Card Authorization				
Other				
Other				
PRIVATE OFFICE: Desk				
Chair				
Book Case				
Telelphone				
Other				
Other				
MECHANICAL: Compressor				
Vacuum Pump				
Air Dryer				
Other				
Other				
LOUNGE: 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
X-RAY EQUIPMENT: Panoramic X-Ray				
Film Processor				
Developing Tank				
Duplicator				
Other				
Other				
TANKS: Nitrous Manifold				
System				
Tank Valves				
Other				
Other				
Other				
Other				
LAB: 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				
STERILIZATION: 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
HYGIENE 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				
Cavitron				
Other				
HYGIENE 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				
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.

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Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				
HYGIENE 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				
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:__________________________
____