

# ***Appraisal Questionnaire***

**Provided By:**



## CONFIDENTIAL APPRAISAL QUESTIONNAIRE (GENERAL DENTISTRY)

Thank you for choosing **Assist to Practice** to assist you in your professional appraisal. A competent third party appraisal is more readily accepted - whether you want to sell a practice, submit an appraisal to a financial/insurance advisor, or just keep current on what your practice is worth - for decision-making and peace of mind. A completed appraisal should be a part of your personal financial portfolio.

### ABOUT THIS QUESTIONNAIRE

This confidential questionnaire is an essential step in establishing a fair market value. Please fill in the information requested as complete as possible. Be assured that we use strict standards of confidentiality. The documents and information requested will be professionally safeguarded. Since your finished appraisal is also valuable in the event of the subsequent sale of all or part of your practice, this questionnaire and the final appraisal are written in the rhetoric of a Practice for Sale.

### KNOWING YOUR PRACTICE VALUE IS AN ASSET

THIS QUESTIONNAIRE IS FOR THE SOLE USE OF **ASSIST TO PRACTICE** IN DETERMINING THE FAIR MARKET VALUE AT THIS POINT IN TIME. THE QUESTIONNAIRE CANNOT BE SHARED OR DISTRIBUTED TO OTHER PARTIES. POSSESSION OF THIS QUESTIONNAIRE OR COPIES DOES NOT CARRY WITH IT THE RIGHT OF PUBLICATION OR DISTRIBUTION...NOR IS IT TO BE USED IN ANY WAY FOR PERSONAL PRACTICE MARKETING OR APPRAISAL WITHOUT THE WRITTEN CONSENT OF **ASSIST TO PRACTICE**.

## TABLE OF CONTENTS

<b>ABOUT THIS QUESTIONNAIRE</b> .....	<b>2</b>
<b>TABLE OF CONTENTS</b> .....	<b>3</b>
<b>SECTION I — PERSONAL INFORMATION:</b> .....	<b>4</b>
<b>SECTION II — PRODUCTION &amp; COLLECTION:</b> .....	<b>5</b>
PRODUCTION.....	5
COLLECTIONS.....	7
CROWN/BRIDGE WORK.....	7
COLLECTION SOURCES.....	8
OFFICE & DOCTOR HOURS.....	8
ACCOUNTS RECEIVABLE.....	8
PROCEDURES PERFORMED.....	9
OWNERS DRAW.....	9
FEE SCHEDULE.....	10
<b>SECTION III — PATIENT PROFILE</b> .....	<b>10</b>
PATIENT TRAFFIC.....	10
NEW PATIENTS.....	10
PATIENT CHARTS.....	10
PENDING TREATMENT.....	11
<b>SECTION IV — OFFICE PROFILE</b> .....	<b>12</b>
OFFICE STAFF & BENEFITS.....	13
OFFICE BUILDING.....	14
<b>SECTION V —ASSETS</b> .....	<b>16</b>
OFFICE TECHNOLOGY.....	16
TELEPHONE SYSTEM.....	16
<b>SECTION VI — CONCLUSION, INITIALS &amp; SIGNATURES</b> .....	<b>17</b>
<b>HARD ASSETS &amp; INVENTORY WORKSHEET</b> .....	<b>18</b>
<b>OWNER’S ACKNOWLEDGEMENT</b> .....	<b>19</b>

## **SECTION I — PERSONAL INFORMATION:**

1. Owner's Full Name \_\_\_\_\_  D.D.S.  D.M.D.  
Dr.'s D.O.B. \_\_\_\_\_ Doctor is:  left-handed  right-handed
2. Business Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone (\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
e-mail \_\_\_\_\_ Website \_\_\_\_\_
3. Town/City Population \_\_\_\_\_ County \_\_\_\_\_
4. Year Graduated \_\_\_\_\_ Specialty School \_\_\_\_\_
5. Practice Name \_\_\_\_\_
6. Year Established \_\_\_\_\_ Date Owner Acquired \_\_\_\_\_
7. Professional Memberships: \_\_\_\_\_  
\_\_\_\_\_  
Civic Activities: \_\_\_\_\_  
\_\_\_\_\_
8. This practice is a ...  
 Sole Proprietorship  Partnership  Corporation  Professional Association  
(If group, please include a copy of your partnership agreement or shareholder agreement and last minutes).  
  
If applicable, list the names and specialties of your partners.  
\_\_\_\_\_  
\_\_\_\_\_
9. Why have you requested this appraisal?  
 Practice for Sale  Partnership  Other \_\_\_\_\_
10. If practice is for sale:  
Does the entire staff know that your practice is for sale?  Yes  No  
Do you want to sell all of it or a portion of it? \_\_\_\_\_  
If a portion, what percentage is for sale? \_\_\_\_\_%
11. Will the phone number stay the same?  Yes  No
12. In the event of illness/death of the owner, has there been an agreement made with other Doctors to cover your duties?  Yes  No
13. Are there any outstanding obligations a buyer may fall heir to?  Yes  No  
\_\_\_\_\_
14. Are there any anticipated or in progress peer reviews or legal actions pending?

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15. Is the owner willing to “Finance” the sale of this practice?  Yes  No  
 Portion \_\_\_\_\_%  All
16. Have you used a Practice consultant in the past five years?  Yes  No  
 If yes, please indicate their name, address and phone number \_\_\_\_\_
- 
17. Please list the name, address and phone number of your accountant.  
 \_\_\_\_\_
18. May we have your permission to contact him/her if needed?  Yes  No
19. Please list the name, address and phone number of your attorney.  
 \_\_\_\_\_
20. May we have your permission to contact him/her if needed?  Yes  No

## **SECTION II — PRODUCTION & COLLECTION:**

### **Production**

21. List your **PRODUCTION** figures, per month, for the past three years and the current year to date. If possible, please separate out figures for Dr.'s and Hygiene production.

#### **2006 Production**

	<b>Dr. 1</b>	<b>+</b>	<b>Dr. 2</b>	<b>+</b>	<b>Hygiene</b>	<b>=</b>	<b>TOTAL</b>
JAN		+		+		=	
FEB		+		+		=	
MAR		+		+		=	
APR		+		+		=	
MAY		+		+		=	
JUN		+		+		=	
JUL		+		+		=	
AUG		+		+		=	
SEP		+		+		=	
OCT		+		+		=	
NOV		+		+		=	
DEC		+		+		=	
<b>TOTAL</b>		<b>+</b>		<b>+</b>		<b>=</b>	

PRODUCTION (Con't)  
**2007 Production**

	Dr. 1	+	Dr. 2	+	Hygiene	=	TOTAL
JAN		+		+		=	
FEB		+		+		=	
MAR		+		+		=	
APR		+		+		=	
MAY		+		+		=	
JUN		+		+		=	
JUL		+		+		=	
AUG		+		+		=	
SEP		+		+		=	
OCT		+		+		=	
NOV		+		+		=	
DEC		+		+		=	
TOTAL		+		+		=	

**2008 Production**

	Dr. 1	+	Dr. 2	+	Hygiene	=	TOTAL
JAN		+		+		=	
FEB		+		+		=	
MAR		+		+		=	
APR		+		+		=	
MAY		+		+		=	
JUN		+		+		=	
JUL		+		+		=	
AUG		+		+		=	
SEP		+		+		=	
OCT		+		+		=	
NOV		+		+		=	
DEC		+		+		=	
TOTAL		+		+		=	

**2009 Production Year To Date**

	Dr. 1	+	Dr. 2	+	Hygiene	=	TOTAL
JAN							

**2009 Production Year To Date**

FEB					
MAR					
APR					
MAY					
JUN					
JUL					
AUG					
SEP					
OCT					
NOV					
DEC					
TOTAL					

**Collections**

22. List your **TOTAL COLLECTION** figures, per month for the past three years and the current year to date. (Actual deposits)

	2006		2007		2008		YTD 2009
JAN							
FEB							
MAR							
APR							
MAY							
JUN							
JUL							
AUG							
SEP							
OCT							
NOV							
DEC							

**Crown/Bridge Work**

23. Please provide the total production for **CROWN & BRIDGE** work for the past three years, PLUS current year.

	AMOUNT
2006	
2007	
2008	
YTD 2009	

24. Average monthly collections needed to pay practice bills **before** owner Doctor can be paid (break even point) \$ \_\_\_\_\_
25. What **percentage** of collections, over the last three years, was from the following sources?

**Collection Sources**

	CASH	MEDICAID	CAPITATION*	PPO*	INSURANCE
2006					
2007					
2008					
2009 YTD					

\* Are contracts transferable?

**Office & Doctor Hours**

26. Please list your office Hours below:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

27. How many days do you normally work per month? \_\_\_\_\_ Per Year? \_\_\_\_\_.
28. How many hours do you work per week? \_\_\_\_\_
29. Do you utilize hygienists? If yes, how many? \_\_\_\_\_  Yes  No  
 How many days do they work per month? \_\_\_\_\_  
 How many hours per day? \_\_\_\_\_  
 Do your hygienists utilize assistants?  Yes  No
30. Do you utilize an in-house lab technician?  Yes  No  
 How many hours does he/she work per month? \_\_\_\_\_

**Accounts Receivable**

31. List your **Accounts Receivable** balances for the last three years.

	BALANCE
2006	
2007	
2008	
2009 YTD	

CURRENT A/R BALANCE YTD... \$ \_\_\_\_\_

For the last complete month indicate the Account Receivable breakdown:

AGE	DOLLAR AMOUNT
Less than 30 days	\$
31 – 60 days	\$
61 – 89 days	\$
Over 90 days	\$
Total	\$

32. What amounts not included in production figures were written off, adjusted or bartered in the past three years?

	ADJUSTMENT	BARTER AMOUNT
2006		
2007		
2008		
2009 YTD		

**Procedures Performed**

33. What **percentage** of your practice production is:

	2006	2007	2008	2009 YTD
Recall				
Restorative*				
Surgery				
Cosmetic				
Other **(Explain)				

\*Include Crown and Bridge in Restorative figure

\*\*

Circle the services performed in your office:

- |                     |                            |                     |
|---------------------|----------------------------|---------------------|
| Endodontics         | Periodontics               | Operative Dentistry |
| Geriatric Dentistry | Prosthodontics – Fixed     | Oral Surgery        |
| Pediatric Dentistry | Prosthodontics – Removable | Orthodontics        |

Indicate the types of treatment referred out of your office: \_\_\_\_\_

**Owners Draw**

34. State your **personal draw** taken from the practice each year (this amount may be different from that which is reported on tax statements).

	PERSONAL USE	DEBT SERVICE	BENEFITS/ INSURANCE	PERSONAL TAXES	TOTAL
2006		+	+	+	=
2007		+	+	+	=
2008		+	+	+	=
2009 YTD		+	+	+	=



How Far Back? \_\_\_\_\_

Yes  No

42. In the office you use:

Family Folders

Individual Folders

**Pending Treatment**

43. Do you have a tracking or pending treatment system in your office?

(i.e., how much work remains in your charts to be done?)

Yes  No

If yes-approximately how much \$ \_\_\_\_\_ TX Pending

Approximate # of charts containing pending TX \_\_\_\_\_

**NOTE: Pending TX booked is an asset. Practice value is greatly affected by this number.**

**SECTION IV — OFFICE PROFILE**

44. Delivery System?  
 Practice 4-handed dentistry  
 Operate from preset-up trays

45. Does the practice have a written marketing plan?  Yes  No  
If so, please enclose a copy.

Please describe how the practice has been promoted. List specific tactics and media or attach a copy of marketing plan. Also, please describe recall system.

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46. Please include the practice mission statement if applicable:

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47. OSHA COMPLIANCE: Does the Practice currently operate in compliance with OSHA and other regulatory guidelines?  Yes  No

What specific Steps have been taken to insure the staff is knowledgeable and in compliance about OSHA guidelines and to insure that they are being followed?

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48. Total outstanding "fixed" practice debt still owed? \$ \_\_\_\_\_  
 Please list below (i.e. equipment, leaseholds, loans etc.)

Items (Notes-Inventory)	Creditor	Mo. Payment	Original Balance	Balance Owed	Payoff Date	Assumable ?
						Y N
						Y N
						Y N
						Y N
						Y N

**Office Staff & Benefits**

49. COMPLETE STAFF ROSTER/SALARIES

Name	Title	Hours Per Week	Still Avaliable?	Date Hired	Present Salary	Date of Last Raise

Are any of the staff related to the doctor? If so, please list names and responsibilities:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check ( ✓ ) the Benefits provided for personnel:

- One Week Paid Vacation     Paid Holidays \_\_\_\_\_ Days/Yr.     Health Benefits/Insurance
- Two Weeks Paid Vacation     Profit Sharing     Employee & Family Dental Benefits
- Three Weeks Paid Vacation     Pension Plan     Other: \_\_\_\_\_

50. How do you rate the salaries of office staff in comparison to the surrounding area? \_\_\_ Low \_\_\_ Average \_\_\_ High

51. Do you have any associates in your office? # \_\_\_\_\_  Yes  No  
 How many days/week does he/she work? \_\_\_ Hours/Week \_\_\_  
 How long have they been there? \_\_\_\_\_

How are they compensated? \_\_\_\_\_

52. Explain any credit programs or policies in your office \_\_\_\_\_

What credit cards do you accept in the office?

53. Rate the following from 1 to 5 (5 being the highest).

Location	_____	Decor/Image	_____
Parking	_____	Signage	_____
Facility condition	_____	In-office patient flow	_____
Patient IQ	_____	Personnel attitude	_____
Drs. Comm. Skills	_____	Util. of expanded functions	_____
Longevity of Staff	_____	Management Systems	_____

54. Explain your practice's economic strengths. \_\_\_\_\_

55. Explain the weak points of your practice. \_\_\_\_\_

56. Do you think your location is good for your practice? Explain \_\_\_\_\_

57. How many competing dentists, in your specialty, are located within a 2-mile radius of your office? \_\_\_\_\_

### Office Building

58. Do you have room to expand your practice?  Yes  No

59. What is the size of your main office? \_\_\_\_\_ Sq. Ft.

60. What is your approximate Rent/Mortgage payment per month? \$ \_\_\_\_\_

61. Who is the owner of the building? \_\_\_\_\_

62. Would the building be for sale?  Yes  No

63. What year was the building constructed? \_\_\_\_\_ Remodeled? \_\_\_\_\_  
What is the office square footage? \_\_\_\_\_

64. Amount of money YOU spent on original Leasehold improvements. \_\_\_\_\_

65. Have there been improvement made to the building in the past five years?  
Amount paid \$ \_\_\_\_\_  Yes  No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

66. List the date of office Renovation or refurbishment. \_\_\_\_\_

67. If you are **Leasing** or **Renting**:

\*How often are you assessed an increase? \_\_\_\_\_ % of increase = \$ \_\_\_\_\_

\*Can the facility agreement be transferred?  Yes  No

\*When is your next lease renewal option? \_\_\_\_\_

\*Are you aware of any possibility that the terms may change?  Yes  No

If yes, explain. \_\_\_\_\_  
\_\_\_\_\_

68. Are you aware of any anticipated property zone changes?  Yes  No  
If yes, explain \_\_\_\_\_  
\_\_\_\_\_

69. Who will provide your equipment and supply appraisal? \_\_\_\_\_

Equipment Appraisal should be submitted on **Supply Company letterhead** and should include the year of purchase, as well as the approximate purchase price. Equipment Appraisal should reflect current, depreciated value and not the Replacement Value.

70. Total # of operatories? \_\_\_\_\_ #Equipped Dr. \_\_\_\_\_ #Equipped Hyg. \_\_\_\_\_  
Please give a brief description of your facility: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

71. Is there anyone else occupying the facility?  Yes  No  
If yes, explain \_\_\_\_\_  
\_\_\_\_\_

## SECTION V –ASSETS

72. Please complete and sign the following **Hard Asset Worksheet** found at the back of this questionnaire. Must be complete before submitting questionnaire.

### Office Technology

73. Is your office computerized? (See Hard Asset Worksheet)  Yes  No

Operating System?	_____		
Total number of Terminals?	_____		
Locations of Terminals?	_____		
Software Name?	_____		
Date of last upgrade?	_____		
Describe Upgrades:	_____		
Printer Model(s)	_____		
Software/Support Contract	\$	Contract	\$
Hardware/Support Contract	\$	Contract	\$

List the functions utilized by the computer:

\_\_\_\_\_

\_\_\_\_\_

74. The office utilizes:
- Peg Board Ledger System
  - Tickler Recall Card System
  - Color Coded Patient Folders
  - Computer Scheduling & Billing

### Telephone System

75. Telephone System: (See hard Assets)

Brand/Type: \_\_\_\_\_

Purchase Date: \_\_\_\_\_

Number of Telephone units \_\_\_\_\_

Number of phone lines \_\_\_\_\_ # Possible? \_\_\_\_\_

Do you currently have a service contract? \_\_\_\_\_ Phone: \_\_\_\_\_

Please check the features of your phone system?

<input type="checkbox"/> Comm. Line	<input type="checkbox"/> Speaker phone
<input type="checkbox"/> Hold capabilities	<input type="checkbox"/> Headset Capabilities

**SECTION VI – CONCLUSION, INITIALS & SIGNATURES**

76. Is there any other information that you feel would be pertinent to this appraisal?

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77. The owner acknowledges his/her professional and financial responsibility as owner of notifying each patient of record if this practice is sold?  
(Please initial) \_\_\_\_\_

78. The owner acknowledges that the appraisal of this practice is based upon the assumption that the owner will agree to a restrictive covenant **Not To Compete** in the geographical area? (Please initial) \_\_\_\_\_

**See Checklist for additional materials needed.**

INFORMATION COMPILED BY: \_\_\_\_\_  
Name Date

By signing here below, I agree that the information, data, figures, and reports provided in and with this Questionnaire are true and correct to the best of my knowledge. They accurately reflect the nature and business of my practice.

REVIEWED/APPROVED BY **OWNER/REPRESENTATIVE**:  
\_\_\_\_\_  
Signed Date

Mail to: **Assist to Practice**  
**TAWC Enterprises llc**  
457 E Northridge Dr  
Kuna ID 83634  
Fax to: (765) 382-1819  
Scan and Email to: [Success@AssistToPractice.com](mailto:Success@AssistToPractice.com)  
On: \_\_\_\_\_  
Date

**THANK YOU!!**

**SERVICE REFERRALS ARE APPRECIATED**



DESCRIPTION	APPROX. PURCHASE DATE	APPROX. PURCHASE PRICE	CURRENT CONDITION (FAIR, GOOD, EXCELLENT)	ADDITIONAL COMMENTS
<b>III. BUSINESS OFFICE EQUIPMENT</b>				
Telephone System		\$		
Computer System		\$		
Scanner		\$		
Copier(s)		\$		
Fax(s)		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		
		\$		

### Owner's Acknowledgement

I, \_\_\_\_\_, do hereby agree that the above stated items, purchase dates, purchase prices, conditions, and estimated values are true and correct to the best of my knowledge. They accurately reflect the quantity and quality of the assets in my office.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_