



Information Summary

PERSONAL INFORMATION

Name _____ ☒ DDS ☐ DMD

Office address _____

Home address _____

Office phone _____ Home phone _____

Email address _____ Web site _____

Education:	Degree	Year graduated	Institution
Undergraduate	_____	_____	_____
Graduate	_____	_____	_____
Post-graduate	_____	_____	_____

Marital Status: ☐ single ☒ married ☐ divorced

Number of children and ages _____

Does your spouse work in the office? ☐ Yes ☐ No

If yes, in what capacity? _____

Health: Age: _____

Do you currently have any health problems? ☐ Yes ☐ No

Do you have an infectious disease? ☐ Yes ☐ No

If yes, please explain _____

Owner's time away from practice each year _____

Type of practice _____

How long established _____

How long at present location _____

Accountant _____ Office phone _____

Attorney _____ Office phone _____

Have you ever been found guilty, entered a plea of "no contest", or been a party to a consent degree with regards to:

Felony? ☐ Yes ☐ No

Malpractice claim? ☐ Yes ☐ No

Other criminal or civil litigation? ☐ Yes ☐ No

Charge of fraud or tax avoidance with
regard to any federal or state taxes? ☐ Yes ☐ No

Bankruptcy? ☐ Yes ☐ No

Disciplinary action taken by the State Dental Board? ☐ Yes ☐ No

If yes to any of these, please explain _____

OPERATIONS:

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Office:	_____	_____	_____	_____	_____	_____
Owner/Dentist	_____	_____	_____	_____	_____	_____
Associate	_____	_____	_____	_____	_____	_____
Associate	_____	_____	_____	_____	_____	_____
Hygienist	_____	_____	_____	_____	_____	_____
Hygienist	_____	_____	_____	_____	_____	_____
Hygienist	_____	_____	_____	_____	_____	_____
Lunch	_____	_____	_____	_____	_____	_____

PERSONNEL:

Name	Position	Day/Hours Worked	Lgth. of Service	Pay/Benefits
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PATIENT'S METHOD OF PAYMENT:

_____ % 1. Cash or Check _____ % 4. PPO (a PPO is any insurance you work off of their fee schedule)
_____ % 2. Private Insurance _____ % 5. HMO
_____ % 3. Government/Welfare _____ % 6. Other _____

Is your office computerized? ☐ Yes ☐ No

What Practice Management Software? _____

If yes what information is on computer? _____

The undersigned dentist hereby warrants and represents that the statements and answers made above and the attachments hereto are true and that I have not omitted or misrepresented any information.

Signed _____



APPRAISAL INFORMATION

Please provide the following items as soon as possible. Do not send originals.

1. The attached questionnaire should be completed. Please type or print neatly.
2. Complete copies of your federal tax returns for the past 3 years. If the practice is incorporated submit your "1120" U.S. Corporate Income Tax Return for each of the last 3 years. If your practice is not incorporated, submit your Schedule C from your personal return (1040) for each of the last 3 years. Be sure to also include the accompanying schedule that itemizes "other expenses" or "other deductions".
3. If your practice is a corporation, W2s or 1099s for all dentists employed including the practice owner for the last 3 years.
4. If your income includes any of the following items, please list the exact amount for each of the past 3 years:

	2023	2024	2025
Orthodontics	_____	_____	_____
PPOs	_____	_____	_____
Public Aid	_____	_____	_____
HMOs & Capitation	_____	_____	_____

5. If you have a monthly or quarterly income statement for the current year and year end statements for the previous three years, please include these documents. If you do not, then please include your monthly production and collections for each month in the current year.
6. Patient Information:

Number of Active Patient Charts (Patients seen within the last 2 years)	_____
Number of New Patients Seen Per Month	_____
Average Number of Patients Seen a Day	_____
Number of Recalls Sent Per Month	_____
7. Computerized printout of all production of the most recent year broken down by procedure or code. It should include quantity of each procedure produced and the total dollar amount for all production for the year for each procedure.

8. Aged Accounts Receivable Schedule

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

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

11. Hygiene Program

	<u>Total Hygiene Gross</u>
2023	\$ _____
2024	\$ _____
2025	\$ _____

12. Estimated square footage of the office _____ sq.ft.

13. If you lease, please include a copy of your current lease and all renewal options. If you own the real estate, you have two possibilities:

A. If you want to continue to own the real estate after selling your practice, you can continue to do so. What rent do you wish to charge the purchaser of your dental practice? Rent \$ _____ Who will pay the property taxes, insurance, and repairs?

B. If you want to sell the real estate at the same time that the practice is sold, we will eventually need an appraisal by a state licensed real estate appraiser.

14. We need an appraisal of all the tangible assets in the dental office including the equipment, supplies, office equipment, and office furniture. You can use your own dental equipment supply house or independent dental repair person to do the appraisal. If you do so, don't tell them that you are selling your practice

We highly recommend using Steinman Services. He has done hundreds of practice appraisals for ADS Midwest and has always done a great job.

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