DENTAL TRANSITIONS™

VALUATIONS | SALES | CONSULTING

# Practice Valuation Application


**ADS Lovelace and Associates, Inc.**

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# PRACTICE PROFILE

***Please* print *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.***

## 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 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: _____

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 & balance sheet)
__ 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.
__ 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 $4,500 (fee waived if application returned with signed practice listing agreement)

***(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:_____

## 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: _____

| | | | Former Owner | Current Status of Former Owner |
|---|---|---|---|---|
| Did you Purchase your practice? | __ Yes | __ No When _____ | _____ | _____ |
| 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 |
| __ | __ | __ | ○ Do you have a contract with your associate? Formula: _____ |
| __ | __ | __ | ○ 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_____

### *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

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: $_____

## Reduced Fee Plans

| Plan | % of pts. on plan | % of your fee paid by plan | Plan | % of pts. on plan | % of your fee paid by plan |
|---|---|---|---|---|---|
| _____ | _____% | _____% | _____ | _____ | _____% |
| _____ | _____% | _____% | _____ | _____ | _____% |
| _____ | _____% | _____% | _____ | _____ | _____% |
| _____ | _____% | _____% | _____ | _____ | _____% |
| _____ | _____% | _____% | _____ | _____ | _____% |
| _____ | _____% | _____% | _____ | _____ | _____% |
| _____ | _____% | _____% | _____ | _____ | _____% |
| _____ | _____% | _____% | _____ | _____ | _____% |

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 is the balance of Patient Credits? $_____

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** $_____ 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 $**_____

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 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 _____

_____

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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.*

*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.*

| | Quantity | Manufacturer | *Approx. Date of Purchase | Description |
|---|---|---|---|---|
| HYGIENE 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 | | | | |
| 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?_____
_____

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

Any other information that would be helpful in describing your practice_____
_____
_____