
PRACTICE APPRAISAL APPLICATION

PPC of New Jersey, Inc.

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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 _____ Cell Phone Number _____

Home Phone Number _____ Home Fax _____

Home Street Address _____

City _____ State _____ Zip _____

Accountant Name _____

Accountant Street Address _____

City _____ State _____ Zip _____

Accountant E-Mail _____

Accountant Phone _____ Accountant Fax _____

Attorney Name _____ Attorney Firm Name _____

Attorney Street Address _____

City _____ State _____ Zip _____

Attorney E-Mail _____

Attorney Phone _____ Attorney Fax _____

Leasing Company _____

Leasing Agent Name _____

Leasing Agent Street Address _____

City _____ State _____ Zip _____

Leasing Agent Phone _____ Leasing Agent Fax _____

How did you hear about Professional Practice Consultants? _____

List of Items Required

Please forward the following items as soon as possible:

- _____ Last three years Schedule C from personal tax return 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 (\$1,000 if seller listing agreement is signed).

- _____ 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 _____
% Practice Income from Insurance _____
% of Patients with Insurance _____
% Practice Income from HMO _____
% of Patients with HMO _____
% Practice Income from PPO _____
% of Patients with PPO _____
% Practice Income from Capitation _____
% of Patients with Capitation _____
% Practice Income from Medicaid _____
% of Patients with Medicaid _____
% Practice Income with Reduced Fee Plan _____
% of Patients with with Reduced Fee Plans _____

Office Hours:

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____
Saturday _____

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)	<u>100%</u>

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
Receptionist	_____	_____	_____
Office Manager	_____	_____	_____
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 _____ to _____	Last Year	Two Years Ago
Gross Production	_____	_____	_____
Hygienists	_____	_____	_____
Owner	_____	_____	_____
Associate	_____	_____	_____
Associate	_____	_____	_____
Associate	_____	_____	_____

How is associate compensated? Amount?	Salary \$ _____	Commission _____ %
How is hygienist 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 patients _____ 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 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 _____

Equipment List

Reception

personal	corporation	quantity	description
_____	_____	_____	Waiting Room Chairs
_____	_____	_____	Waiting Room Tables
_____	_____	_____	Waiting Room Lamps
_____	_____	_____	Pictures/Decorations
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Business Office

personal	corporation	quantity	description
_____	_____	_____	Business Office Desk
_____	_____	_____	Business Office Chair
_____	_____	_____	Copy Machine
_____	_____	_____	File Cabinets
_____	_____	_____	Typewriter
_____	_____	_____	Computer
_____	_____	_____	Printer
_____	_____	_____	Software
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Private Office

personal	corporation	quantity	description
_____	_____	_____	Desk
_____	_____	_____	Chair
_____	_____	_____	Bookcase
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Lounge

personal	corporation	quantity	description
_____	_____	_____	Refrigerator
_____	_____	_____	Table & Chairs
_____	_____	_____	Microwave
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Mechanical

personal	corporation	quantity	description
_____	_____	_____	Compressor
_____	_____	_____	Vacuum Pump
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

X-Ray Equipment

personal	corporation	quantity	description
_____	_____	_____	Panorex X-Ray
_____	_____	_____	Film Processor
_____	_____	_____	Developing Tank
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Tanks

personal	corporation	quantity	description
_____	_____	_____	Nitrous Manifold System
_____	_____	_____	Tank Valves
_____	_____	_____	Air Dryer
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Lab

personal	corporation	quantity	description
_____	_____	_____	Model Trimmer
_____	_____	_____	Lathe
_____	_____	_____	Furnace
_____	_____	_____	Splash Hood with Shield
_____	_____	_____	Vibrator
_____	_____	_____	Casting Machine
_____	_____	_____	Suck Down Unit
_____	_____	_____	Wax Dripping Pot
_____	_____	_____	Porcelain & Opaque
_____	_____	_____	Powder Mixer
_____	_____	_____	Articulators
_____	_____	_____	Surveyor
_____	_____	_____	Plastic Bins

Lab Continued

personal	corporation	quantity	description
_____	_____	_____	Vacuum Pump
_____	_____	_____	Lab Handpieces
_____	_____	_____	Other
_____	_____	_____	Other

Sterilization

personal	corporation	quantity	description
_____	_____	_____	Auto Clave
_____	_____	_____	Ultrasonic Cleaner
_____	_____	_____	Other
_____	_____	_____	Other

Hygiene #1

personal	corporation	quantity	description
_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	Cavitron
_____	_____	_____	High Speed Handpieces
_____	_____	_____	Low Speed Handpieces
_____	_____	_____	Misc. Handpieces
_____	_____	_____	Burs
_____	_____	_____	Curing Light
_____	_____	_____	Cabinets
_____	_____	_____	X-Ray Units
_____	_____	_____	X-Ray View Box
_____	_____	_____	Nitrous Flow Meter
_____	_____	_____	Amalgamator
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Hygiene #2

personal	corporation	quantity	description
_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	Cavitron
_____	_____	_____	High Speed Handpieces
_____	_____	_____	Low Speed Handpieces
_____	_____	_____	Misc. Handpieces
_____	_____	_____	Burs
_____	_____	_____	Curing Light
_____	_____	_____	Cabinets
_____	_____	_____	X-Ray Units
_____	_____	_____	X-Ray View Box
_____	_____	_____	Nitrous Flow Meter
_____	_____	_____	Amalgamator
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Hygiene #3

personal	corporation	quantity	description
_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	Cavitron
_____	_____	_____	High Speed Handpieces
_____	_____	_____	Low Speed Handpieces
_____	_____	_____	Misc. Handpieces
_____	_____	_____	Burs
_____	_____	_____	Curing Light
_____	_____	_____	Cabinets
_____	_____	_____	X-Ray Units
_____	_____	_____	X-Ray View Box
_____	_____	_____	Nitrous Flow Meter
_____	_____	_____	Amalgamator
_____	_____	_____	Other
_____	_____	_____	Other
_____	_____	_____	Other

Office Layout

Please provide diagram of office layout (may be hand drawn).