



We appreciate your time gathering information about your practice and goals. Please answer the following questions to the best of your ability. This will provide Smarter Practice Solutions with the information necessary to have a valuable discussion regarding the opportunities in your practice. Should you have any questions, please contact us at 888.765.0990. Email your completed form to info@smarterpracticesolutions.com or fax to 888.765.0880. The information provided is strictly confidential and will not be shared with any other person or party outside Smarter Practice Solutions.

BUSINESS INFORMATION

Name of Practice: _____ Specialty: _____

Name of Dentist: _____ Additional Owner Name(s): _____

Business Address: _____

City, State, Zip Code: _____

Telephone: _____ Facsimile: _____

Email: _____ Website: _____

TEAM & CALENDAR INFORMATION

Hours of Operation:

MONDAY:	_____ AM	_____ PM	_____ Lunch
TUESDAY:	_____ AM	_____ PM	_____ Lunch
WEDNESDAY:	_____ AM	_____ PM	_____ Lunch
THURSDAY:	_____ AM	_____ PM	_____ Lunch
FRIDAY:	_____ AM	_____ PM	_____ Lunch
SATURDAY:	_____ AM	_____ PM	_____ Lunch

Please list dentists working within the practice:

Name	Dental School	Grad Year	Specialty
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please provide the name of each doctor, hygienist and additional team member working within the practice. Indicate the days and hours worked for each provider and non-provider.

Name	Job Role	Mon	Tues	Wed	Thurs	Fri	Sat
Dr. Sample	Owner	8am - 5pm	8am - 5pm	8am-5pm	8am-5pm	NA	NA

Name	Job Role	Mon	Tues	Wed	Thurs	Fri	Sat

FINANCIAL INFORMATION

Use the most recent completed 12 months as a guideline - Indicate Date Range: _____

Total Annual Practice Production: \$ _____ Circle one: Gross Net

Total Annual Practice Collection: \$ _____

Total Production Adjustments: \$ _____ Insurance Par Adjustments: \$ _____

Total Accounts Receivables: \$ _____ Over 90 days: \$ _____

Please list the insurance plans you participate with: _____

When is the last time you updated your fees?: _____ Indicate % change: _____

What growth percentage did you achieve last calendar year? _____ Are you satisfied with your growth? _____

Estimate your total practice overhead (excluding owner-doctor compensation): _____ %

Doctor #1 Revenue Hours Per Week: _____ # of Weeks Per Year: _____ Annual Production: \$ _____

Doctor #2 Revenue Hours Per Week: _____ # of Weeks Per Year: _____ Annual Production: \$ _____

Doctor #3 Revenue Hours Per Week: _____ # of Weeks Per Year: _____ Annual Production: \$ _____

Doctor #4 Revenue Hours Per Week: _____ # of Weeks Per Year: _____ Annual Production: \$ _____

Total Hygiene Revenue Hours Per Week: _____ # of Weeks Per Year: _____ Annual Production: \$ _____

PATIENT BASE INFORMATION

Use the last three complete months as a guideline - Indicate Date Range: _____

Average # of New Patients - per month (D0150 only): _____ Of those, how many are referred by existing patients? _____

Average # of New Patient - per month emergencies: _____ Of those, how many convert to patients of record? _____

of New Patients seen nine months ago: _____ Of those, how many have a future scheduled appointment? _____

of hygiene visits in the last six months: _____
_____ Month 1
_____ Month 2
_____ Month 3
_____ Month 4
_____ Month 5
_____ Month 6

of periodontal procedures in the last three months: _____
_____ Month 1
_____ Month 2
_____ Month 3

of patients with a future scheduled hygiene appointment: _____ Length of adult recare visit: _____

When was the last time you expanded available hygiene hours?: _____ By how many?: _____

FACILITY INFORMATION

of Equipped Treatment Rooms: _____ # of Unequipped Treatment Rooms: _____

Please list additional rooms (i.e. consult, private doctor's office, etc.): _____

Room to expand in current facility: _____ Lease or Own Facility? _____

Vision for facility expansion/ownership/relocation:

PRACTICE GOALS

Tell us a little about your practice philosophy and goals - Use separate sheet if necessary:

What are your personal and professional goals in the next five to ten years?

What opportunities do you see for practice growth?

What do you feel is preventing you from achieving your growth potential?

Have you ever worked with a dental practice management coach in the past? Please share your experience.

Additional Comments:
