SUMMITBANK

DENTAL PRACTICE PROFILE

Acquisition

SELLER'S INFORMATION

Name:	Practice Name:		
Street Address:	City:	State:	ZIP Code:
Business Phone number:	Fax Number:	Email Address:	

BUYER'S EDUCATION AND WORK HISTORY

School:			Graduation Date:	
Job Title #1:	Practice Name:	City:	State:	Date employed (MM/YYYY):
Job Title #2:	Practice Name:	City:	State:	Date employed (MM/YYYY):

Have you ever owned a practice? ☐ Yes ☐ No	Do you currently own any other practice? ☐ Yes ☐ No

REVENUE AND PROCEDURE DATA

Payment by cash _____% Insurance _____% Medicaid _____% Capitation _____%	Patients fee-for-service _____% Production from Delta Dental _____%

Crown/bridge	_____ %	Endodontics	_____ %	Pediatrics	_____ %
Restorative	_____ %	Oral Surgery	_____ %	Orthodontics	_____ %
Hygiene & Exams	_____ %	Dentures	_____ %	Other	_____ %
Implants	_____ %	Periodontics	_____ %		

Are there any procedures you're unable to perform? ☐ Yes ☐ No	If yes list procedure(s):
Are there any additional procedures you can perform? ☐ Yes ☐ No	If yes list procedure(s):

List insurance plans that represent more than 20% of total collections:

Do you plan to become contracted with the same insurance plans currently accepted by the seller? ☐ Yes ☐ No

Number of active patients, seen in past 18 months:	Average new patients per month, over last 6 months:

Does the practice currently track source(s) of new patients? ☐ Yes ☐ No

Number of doctor vacation/sick days in prior calendar year: In Current year (YTD):

Historically, which quarter of the year is the practice's most productive? ☐Q1 ☐Q2 ☐Q3 ☐Q4 Least Productive ☐Q1 ☐Q2 ☐Q3 ☐Q4

OFFICE PROFILE

Office Size (in Sq. ft.):	Total number of operatories:	Total equipped operatories:

Quality of office improvements: *(check one)* ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Quality of office equipment: *(check one)* ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Radiography: *(check one)* ☐ Digital ☐ Film-Based

Equipment included with practice: *(check all applicable)* ☐ Digital Panorex ☐ CAD/CAM ☐ Cone beam ☐ Soft-tissue laser

Are there any imminent equipment needs? ☐ Yes ☐ No

If yes, please list and explain the related cost of implementation:

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OFFICE PROFILE						
Current office hours						
MON:	TUS:	WEN:	THU:	FRI:	SAT:	SUN:

☐ New Lease ☐ Assumption	Date of lease expires: (MM/DD/YYYY)
Renewal options? ☐ Yes ☐ No	Office location ☐1st floor ☐2nd floor ☐3rd floor ☐4th floor
Building type: *(check one)* ☐ Free-standing ☐ Shopping Center ☐ Medical complex ☐ Other professional center	

Title	Name	Salary or Commission	Hours	Years Employed	Production (Annual)
Owner doctor					
Associate #1					
Associate #2					
Hygienist #1					
Hygienist#2					
Hygienist#3					
Front desk #3					
Front desk #2					
Assistant #1					
Assistant #2					
Other #1					
Other#2					

Is staff aware of the sale? ☐ Yes ☐ No

If any staff are in the seller's immediate/extended family, list here_____

If not all staff are staying with practice after sale, list those leaving_____

How long has seller been at this location? Have you performed a chart audit ☐ Yes ☐ No If yes, approx. how many files_____	Will seller remain after sale? ☐ Yes ☐ No If yes, how long?_____ months_____ years Estimated annual compensation_____

Please describe your primary reasons for purchasing this practice:

Please describe any changes you will implement at this practice and future goals: