



# DENTAL PRACTICE PROFILE

## Refinance

| DOCTOR'S INFORMATION  |                |  |                |  |                  |                     |
|---|----------------|--|----------------|--|------------------|---------------------|
| Name:   |                | Practice Name:   |                |  |                  |                     |
| Street Address:   |                | City:  | State:         | ZIP Code:  |                  |                     |
| Business Phone number:  |                | Fax Number:  | Email Address: |  |                  |                     |
| DOCTOR'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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                | Do you currently own any other practice?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                |  |                  |                     |
| OFFICE PROFILE  |                |  |                |  |                  |                     |
| Office Size (in Sq. ft.):   |                | Total number of operatories:   |                | Total equipped operatories:  |                  |                     |
| Do you own the building/office? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                | If no, what is your monthly rent payment? \$   |                |  | Expiration Date: |                     |
| Quality of office improvements: <i>(check one)</i> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor   |                |  |                |  |                  |                     |
| Quality of office equipment: <i>(check one)</i> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor  |                |  |                | Radiography: <i>(check one)</i> <input type="checkbox"/> Digital <input type="checkbox"/> Film-Based |                  |                     |
| Equipment included with practice: <i>(check all applicable)</i> <input type="checkbox"/> Digital Panorex <input type="checkbox"/> CAD/CAM <input type="checkbox"/> Cone beam <input type="checkbox"/> Soft-tissue laser |                |  |                |  |                  |                     |
| Are there any imminent equipment needs? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                |  |                |  |                  |                     |
| If yes, please list and explain the related cost of implementation:   |                |  |                |  |                  |                     |
|   |                |  |                |  |                  |                     |
| Current office hours  |                |  |                |  |                  |                     |
| MON:  | TUS:           | WEN:   | THU:           | FRI:   | SAT:             | SUN:                |
| Office location<br><input type="checkbox"/> 1 <sup>st</sup> floor <input type="checkbox"/> 2 <sup>nd</sup> floor <input type="checkbox"/> 3 <sup>rd</sup> floor <input type="checkbox"/> 4 <sup>th</sup> floor          |                |  |                |  |                  |                     |
| Building type: <i>(check one)</i> <input type="checkbox"/> Free-standing <input type="checkbox"/> Shopping Center <input type="checkbox"/> Medical complex <input type="checkbox"/> 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   |                |  |                |  |                  |                     |



**SUMMIT**BANK

| Debt Schedule |        |           |         |                 |          |
|---------------|--------|-----------|---------|-----------------|----------|
|               | Lender | Loan Type | Balance | Monthly Payment | Comments |
| 1             |        |           |         |                 |          |
| 2             |        |           |         |                 |          |
| 3             |        |           |         |                 |          |
| 4             |        |           |         |                 |          |
| 5             |        |           |         |                 |          |
| 6             |        |           |         |                 |          |
| 7             |        |           |         |                 |          |
| 8             |        |           |         |                 |          |
| 9             |        |           |         |                 |          |