



® Practice Transitions Made Perfect™

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# PRACTICE VALUATION APPLICATION

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**ADS South, LLC**  
120 Istoria Drive  
St. Augustine, FL 32095

770-664-1982  
Fax: 678-965-1812  
info@adssouth.com  
[www.adssouth.com](http://www.adssouth.com)

*All ADS companies are independently owned and operated*

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**Owner Personal Information - Please fill in completely and legibly**

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Degree DDS \_\_\_\_\_ DMD \_\_\_\_\_ Other \_\_\_\_\_ Date of Birth \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Practice Trade Name \_\_\_\_\_

GP or Specialty \_\_\_\_\_ If incorporated, are you a "C" or a "S" Corporation? C \_\_\_\_\_ S \_\_\_\_\_

Corporation Suffix: PC \_\_\_\_\_ PA \_\_\_\_\_ APDC \_\_\_\_\_ LLC \_\_\_\_\_ LLP \_\_\_\_\_ Other \_\_\_\_\_

Name of President / Manager \_\_\_\_\_ Secretary \_\_\_\_\_

Name any other officers and all shareholders by percent interest \_\_\_\_\_

Reason for Appraisal \_\_\_\_\_ Date of Preparation \_\_\_\_\_

What is your website address? \_\_\_\_\_

Practice Street Address \_\_\_\_\_

City \_\_\_\_\_ County/Parish \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Practice Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ May we fax to this number? \_\_\_\_\_

E-mail Address \_\_\_\_\_ Can we send private e-mail to you? \_\_\_\_\_

Website \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Accountant \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

Attorney Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

Leasing Agent Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

How did you hear about ADS South, LLC? \_\_\_\_\_

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## **List of Items Required**

- \_\_\_\_\_ Last three years **Schedule C** from personal tax return **with Statement of Other Expenses, or**
- \_\_\_\_\_ Last three years of the **complete Schedule 1120 or 1120S.**
- \_\_\_\_\_ Latest Year-to-date profit and loss statement for the current year.
- \_\_\_\_\_ Latest year's W-2 forms for employees with employee's position written on each W-2.
- \_\_\_\_\_ Aged Accounts Receivable Report (provide only the one page summary)
- \_\_\_\_\_ Production by Provider report for last year and current year to date
- \_\_\_\_\_ Production by Category report for last year and current year to date
- \_\_\_\_\_ Production and Collection Summary Report
- \_\_\_\_\_ Report of patients by age
- \_\_\_\_\_ Report of patients by zip code or town
- \_\_\_\_\_ Copy of contracts with any associates, partners, or employees
- \_\_\_\_\_ A copy of your office lease.
- \_\_\_\_\_ A copy of any equipment appraisal report
- \_\_\_\_\_ Copies of any equipment leases and list of any leased equipment
- \_\_\_\_\_ Copy of your current fee schedule and fee schedule for any plans
- \_\_\_\_\_ List of loans against practice and payoff balances
- \_\_\_\_\_ Photographs of all rooms and exterior of office.
- \_\_\_\_\_ A diagram of the office layout -- may be hand drawn.
- \_\_\_\_\_ Complete list of all major items to be included in the sale and date of acquisition of major items. (Use list on last pages)
- \_\_\_\_\_ List trade names and addresses of any other practices that you own and any shared employee positions
- \_\_\_\_\_ Appraisal fee of \$2,950 for General Practice or \$3,500 for specialty practices (\$1,000 if executed Sales Consulting Agreement is sent with appraisal information). Call for fees for appraisals involving divorce valuations or testimony.
- \_\_\_\_\_ Your urgency in selling practice. ("10" represents selling in 30 days. "1" represents selling in 2 years.)

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## **Personal Data**

Dental School Alma Mater \_\_\_\_\_ Year Graduated \_\_\_\_\_

Year Beginning Practice in City \_\_\_\_\_ Year Beginning Practice in Current Location \_\_\_\_\_

Right or Left Handed \_\_\_\_\_ Purchase or Scratch Start \_\_\_\_\_

From whom was practice purchased \_\_\_\_\_ What Year \_\_\_\_\_

Gross Income of practice when purchased \$ \_\_\_\_\_ Purchase price of practice \$ \_\_\_\_\_

Professional Organizations \_\_\_\_\_

Post Graduate Degree \_\_\_\_\_ Alma Mater \_\_\_\_\_

Date Completed \_\_\_\_\_ Specialty or Designations \_\_\_\_\_

Board Qualified? \_\_\_\_\_ Board Certified \_\_\_\_\_ States Licensed: \_\_\_\_\_

Do you have an associate? \_\_\_\_\_ Do you have a partner? \_\_\_\_\_

Do you share space? \_\_\_\_\_ Is there an assignable written agreement? \_\_\_\_\_

Is there a buy-out agreement? \_\_\_\_\_ Is there an assignable restrictive covenant? \_\_\_\_\_

What are the terms of the covenant \_\_\_\_\_

What are the terms of the buy-out agreement \_\_\_\_\_

Has an associate or partner left your practice in the last two years? \_\_\_\_\_ When? \_\_\_\_\_

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## **Office Data**

Office Sq. Footage \_\_\_\_\_ Expandable Footage \_\_\_\_\_

Current Monthly Rental Amount \$ \_\_\_\_\_ Is Office Handicapped Accessible? \_\_\_\_\_

Number of Parking Spaces \_\_\_\_\_ Proximity of Parking \_\_\_\_\_

Total Number of Equipped Operatories \_\_\_\_\_ Number of Plumbed But Unequipped Operatories \_\_\_\_\_

Number of Operatories used primarily by dentists \_\_\_\_\_ Number of Operatories used primarily by hygienists \_\_\_\_\_

Number of Unplumbed and Empty Operatories \_\_\_\_\_ Do you or your entity own your building? \_\_\_\_\_

Do you want to sell the building? \_\_\_\_\_ Legal Name of Owner \_\_\_\_\_

Was building appraised? \_\_\_\_\_ When? \_\_\_\_\_ Appraised Price \$ \_\_\_\_\_

If not appraised, estimated price \$ \_\_\_\_\_ If Not for Sale, Monthly Rental Amount \$ \_\_\_\_\_

Annual Property Taxes \$ \_\_\_\_\_ Annual Property Insurance \$ \_\_\_\_\_

If you do not own your office, what is the Date of Lease \_\_\_\_\_ Date Lease Ends \_\_\_\_\_

Describe any renewal options \_\_\_\_\_ Option to Purchase? \_\_\_\_\_

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## **Post-Sale Information**

Plans after the sale of your Practice \_\_\_\_\_

**Days/Week Currently Worked:** \_\_\_\_\_

**Enter number of days/week you would like to work for the buyer after the 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 \_\_\_\_\_

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## **Practice Data**

Has your practice been appraised before? \_\_\_\_\_ When? \_\_\_\_\_ By Whom? \_\_\_\_\_

Previous Appraisal Price \$ \_\_\_\_\_ Have you previously tried to sell your practice? \_\_\_\_\_ When? \_\_\_\_\_

Did you use a broker? \_\_\_\_\_ Who? \_\_\_\_\_ Is your practice currently listed with another broker? \_\_\_\_\_

Who: \_\_\_\_\_ Have you used a management consultant in the past five years? \_\_\_\_\_ Who? \_\_\_\_\_

Results \_\_\_\_\_

Describe any internal marketing \_\_\_\_\_

Describe any external marketing \_\_\_\_\_

Has your practice gross changed significantly? \_\_\_\_\_ Why: \_\_\_\_\_

Do you provide Nitrous Oxide? \_\_\_\_\_ Conscious Sedation or DOCS? \_\_\_\_\_ IV Sedation? \_\_\_\_\_ Mercury free? \_\_\_\_\_

Active patients (how many different patients treated in last 18 months) \_\_\_\_\_ How many new patients per month \_\_\_\_\_

Average number of patients treated per day by dentist \_\_\_\_\_ by hygienist \_\_\_\_\_

How far ahead is owner scheduled? \_\_\_\_\_ Hygienist? \_\_\_\_\_

% Practice Income from Cash \_\_\_\_\_%

% of Patients Paying Cash \_\_\_\_\_%

% Practice Income from full fee Insurance \_\_\_\_\_%

% of Patients with full fee Insurance \_\_\_\_\_%

% Practice Income from reduced fee plans \_\_\_\_\_%

% of Patients with reduced fee plans \_\_\_\_\_%

% Practice Income from Capitation \_\_\_\_\_%

% of Patients with Capitation \_\_\_\_\_%

% Practice Income from Medicaid \_\_\_\_\_%

% of Patients with Medicaid \_\_\_\_\_%

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## **Scheduling Data**

Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_  
Thursday \_\_\_\_\_ Friday \_\_\_\_\_ Saturday \_\_\_\_\_

Owner Hours Worked/Week \_\_\_\_\_ Associate Hours Worked/Week \_\_\_\_\_  
Hygiene 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 \_\_\_\_\_ What is Your Collection Percentage? \_\_\_\_\_  
Actual Accounts Receivable Balance \$ \_\_\_\_\_ What is the Patient Credit Balance? \$ \_\_\_\_\_  
Accounts Receivable: Current \$ \_\_\_\_\_ 30 days \$ \_\_\_\_\_ 60 days \$ \_\_\_\_\_ 90 days \$ \_\_\_\_\_ >90 days \$ \_\_\_\_\_  
What Type Recall System? \_\_\_\_\_ What Type Practice Management Software? \_\_\_\_\_

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## **Collections by Service**

Hygiene \_\_\_\_\_% Operative \_\_\_\_\_% Pedodontics \_\_\_\_\_% Orthodontics \_\_\_\_\_% Implants \_\_\_\_\_%  
Removable Prosthetics \_\_\_\_\_% Fixed Prosthetics \_\_\_\_\_% Endodontics \_\_\_\_\_% Periodontics \_\_\_\_\_%  
Oral Surgery \_\_\_\_\_% Cosmetic \_\_\_\_\_% TMJ Treatment \_\_\_\_\_% Soft Tissue Management \_\_\_\_\_% Other \_\_\_\_\_%  
**TOTAL** (should be 100%) \_\_\_\_\_% What is referred out? \_\_\_\_\_

**Is any of your reported income from any other source than patient treatment from this practice? \_\_\_\_\_ If so, how much for each year?**

**\$ \_\_\_\_\_ in 201 \_\_\_\_\_ \$ \_\_\_\_\_ in 201 \_\_\_\_\_ \$ \_\_\_\_\_ in 201 \_\_\_\_\_**

What is the source of the other income? \_\_\_\_\_

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## **Fee Schedule**

Adult Prophy 01110 \$ _____	Panoramic X-Ray 00330 \$ _____
Two Surface Anterior Composite 02331 \$ _____	Two Surface Posterior Composite 02386 \$ _____
Core Build-Up Including Pins 02950 \$ _____	Crown – Porcelain/Ceramic 06740 \$ _____
Crown - Gold/Porcelain 02750 \$ _____	Labial Porcelain Veneer 02962 \$ _____
Anterior Root Canal 03310 \$ _____	Bicuspid Root Canal 03320 \$ _____

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## Demographic Data

What is the approximate population of your city or town? \_\_\_\_\_ Of your drawing area? \_\_\_\_\_

Major employers in the area \_\_\_\_\_

Describe any major economic changes in your drawing area \_\_\_\_\_

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## Staff Data

<u>Position</u>	<u>Month/Year Hired</u>	<u>Expected to stay?</u>	<u>Annual Value of Benefits</u>	<u>Annual Salary</u>
Receptionist	_____	_____	\$ _____	\$ _____
Office Manager	_____	_____	\$ _____	\$ _____
Insurance	_____	_____	\$ _____	\$ _____
Other Front Desk	_____	_____	\$ _____	\$ _____
Bookkeeper	_____	_____	\$ _____	\$ _____
Assistant	_____	_____	\$ _____	\$ _____
Assistant	_____	_____	\$ _____	\$ _____
Assistant	_____	_____	\$ _____	\$ _____
Assistant	_____	_____	\$ _____	\$ _____
Assistant	_____	_____	\$ _____	\$ _____
Hygienist	_____	_____	\$ _____	\$ _____ or _____ %
Hygienist	_____	_____	\$ _____	\$ _____ or _____ %
Hygienist	_____	_____	\$ _____	\$ _____ or _____ %
Hygienist	_____	_____	\$ _____	\$ _____ or _____ %
Lab Technician	_____	_____	\$ _____	\$ _____
Lab Technician	_____	_____	\$ _____	\$ _____
Associate	_____	_____	\$ _____	\$ _____ or _____ %
Associate	_____	_____	\$ _____	\$ _____ or _____ %
Associate	_____	_____	\$ _____	\$ _____ or _____ %
Other _____	_____	_____	\$ _____	\$ _____
Other _____	_____	_____	\$ _____	\$ _____

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What Benefits do you provide for the staff ? \_\_\_\_\_

Cost of Benefits provided for each employee: \_\_\_\_\_

Do You Hire Any Unpaid Family? \_\_\_\_\_ What position do they hold and what is the estimated fair market value of their job? \_\_\_\_\_

Are there any family or other employees who are paid more/less than the normal salary for their position? \_\_\_\_\_

Which positions and amount of over/under compensation for each? \_\_\_\_\_

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## **Collection Centers**

	Current Year to Date Collections	Last Year Collections	Two Years Ago Collections
Year	1/1/201__ to ____/____/201__	201__	201__
Gross Collections	\$ _____	\$ _____	\$ _____
Owner	\$ _____	\$ _____	\$ _____
Hygienists	\$ _____	\$ _____	\$ _____
Associate	\$ _____	\$ _____	\$ _____
Associate	\$ _____	\$ _____	\$ _____
Associate	\$ _____	\$ _____	\$ _____

How is associate compensated? Amount? \$ \_\_\_\_\_ per year or \_\_\_\_\_ % of collections or production

How is hygienist compensated? Amount? \$ \_\_\_\_\_ per year or \_\_\_\_\_ % of collections or production

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## **Practice Conformity Data**

Does practice meet OSHA standards? \_\_\_\_\_ If not, why not? \_\_\_\_\_

Does practice conform with HIPAA requirements? \_\_\_\_\_ Why not? \_\_\_\_\_

Do you forgive any insurance copayments? \_\_\_\_\_ Explain and how much \_\_\_\_\_





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## **Insurance Explanation**

Total expense for Insurance \$ \_\_\_\_\_ How much of total is for owner health insurance? \$ \_\_\_\_\_

How much of total is for staff health insurance? \$ \_\_\_\_\_ How much of total is for owner life insurance? \$ \_\_\_\_\_

How much of insurance is for owner personal benefits, i.e. disability? \$ \_\_\_\_\_

How much of total is for malpractice? \$ \_\_\_\_\_ How much of total is for building insurance? \$ \_\_\_\_\_

## **Taxes and Licenses Explanation**

Total expense for taxes \$ \_\_\_\_\_ How much of total is for payroll taxes? \$ \_\_\_\_\_

How much of total is for staff payroll tax? \$ \_\_\_\_\_ How much of total is for owner payroll tax? \$ \_\_\_\_\_

How much of total is for ad valorem / property taxes? \$ \_\_\_\_\_ How much of total is for real estate taxes? \$ \_\_\_\_\_

## **Pension Explanation**

Total expense for pension plan \$ \_\_\_\_\_ How much of total is for staff? \$ \_\_\_\_\_

How much of total is for owner? \$ \_\_\_\_\_

## **Benefits Explanation**

Total expense for employee benefits \$ \_\_\_\_\_ How much of total is for staff? \$ \_\_\_\_\_

How much of total is for owner? \$ \_\_\_\_\_

## **Reduced Fee Plans**

<b><u>Plan</u></b>	<b><u>Percent of your standard fee</u></b>	<b><u>Plan</u></b>	<b><u>Percent of your standard fee</u></b>
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %

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## Specialty Practice Supplement for Orthodontic Practices

Total number of patients in treatment: Adult \_\_\_\_\_ Child \_\_\_\_\_ Complete banding treatment patients: Adult \_\_\_\_\_ Child \_\_\_\_\_

Partial banding treatment patients: Adult \_\_\_\_\_ Child \_\_\_\_\_ Number of patients in partial treatment: Adult \_\_\_\_\_ Child \_\_\_\_\_

Patients in retention: Adult \_\_\_\_\_ Child \_\_\_\_\_ Patients in TMJ treatment \_\_\_\_\_

Current contracts balance \_\_\_\_\_ Accounts receivable balance (money past due) \$ \_\_\_\_\_

Number of patients in treatment no longer paying fees \_\_\_\_\_ Attach a detailed list of patients and stage of treatment for each

New starts this year as of Jan. 1, 201 \_\_\_\_\_ New starts in last twelve (12) months \_\_\_\_\_

Cost of average full treatment: Child \$ \_\_\_\_\_ Adult \$ \_\_\_\_\_

Average down payment for records \$ \_\_\_\_\_ Banding \$ \_\_\_\_\_

Average fee per visit \$ \_\_\_\_\_ Average fee per retention patient: Initial \$ \_\_\_\_\_ Periodic \$ \_\_\_\_\_

Average fee for partial treatment: Adult \$ \_\_\_\_\_ Child \$ \_\_\_\_\_

Average fee for TMJ treatment: \$ \_\_\_\_\_

Do you use: Begg \_\_\_\_\_% Edgewise \_\_\_\_\_% Invisalign \_\_\_\_\_% Other - \_\_\_\_\_%

Describe technique, banding, etc. most commonly used: \_\_\_\_\_

\_\_\_\_\_

What percent of your patients are from dentist referrals? \_\_\_\_\_%

Describe your referral base: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Explain the best strengths and worst weaknesses of your practice: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## **Specialty Practice Supplement for Oral Surgery Practices**

What percent of practice is: Exodontia \_\_\_\_\_% Maxillofacial \_\_\_\_\_% TMJ \_\_\_\_\_% Cosmetic \_\_\_\_\_%

Trauma \_\_\_\_\_% Other \_\_\_\_\_% Describe \_\_\_\_\_

Describe typical anesthesia technique for in-office surgery: \_\_\_\_\_

At what hospitals do you have privileges? \_\_\_\_\_

Have you lost privileges at any hospital? \_\_\_\_\_ Which ones? \_\_\_\_\_

What percent of your patients are from dentist referrals? \_\_\_\_\_%

Describe your referral sources (number, ages, etc.) \_\_\_\_\_

Explain the best strengths and worst weaknesses of your practice \_\_\_\_\_

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## **Specialty Practice Supplement for Periodontal Practices**

What percent of practice income is: Implants \_\_\_\_\_% Surgical \_\_\_\_\_% Non-Surgical \_\_\_\_\_% Recall \_\_\_\_\_%

Other \_\_\_\_\_% Describe \_\_\_\_\_

Describe anesthesia techniques used: \_\_\_\_\_

What percent of your patients are from dentist referrals? \_\_\_\_\_%

Do you use a laser? \_\_\_\_\_ What brand? \_\_\_\_\_ Do you have a cone beam X-Ray? Brand? \_\_\_\_\_

Describe implant treatment – brands, etc. \_\_\_\_\_

Describe your referral base: \_\_\_\_\_

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Explain the best strengths and worst weaknesses of your practice \_\_\_\_\_

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# Equipment List

Under Acquired, enter approximate date of purchase

Under Description, enter Make and Model

## Reception

Quantity Acquired   Description

___	___	_____	Waiting Room Chairs
___	___	_____	Waiting Room Tables
___	___	_____	Waiting Room Lamps
___	___	_____	Pictures/Decorations
___	___	_____	
___	___	_____	
___	___	_____	

## Business Office

Quantity Acquired   Description

___	___	_____	Business Office Desk
___	___	_____	Business Office Chair
___	___	_____	Copy Machine
___	___	_____	File Cabinets
___	___	_____	Typewriter
___	___	_____	Computer
___	___	_____	Printer
___	___	_____	Software
___	___	_____	
___	___	_____	
___	___	_____	
___	___	_____	

## Private Office

Quantity Acquired   Description

___	___	_____	Desk
___	___	_____	Chair
___	___	_____	Bookcase
___	___	_____	
___	___	_____	

## Lounge

Quantity Acquired   Description

___	___	_____	Refrigerator
___	___	_____	Table & Chairs
___	___	_____	Microwave
___	___	_____	
___	___	_____	
___	___	_____	

## Mechanical

Quantity Acquired   Description

___	___	_____	Compressor
___	___	_____	Vacuum Pump
___	___	_____	Air Dryer
___	___	_____	
___	___	_____	

**X-Ray Equipment**

Quantity Acquired   Description

\_\_\_\_\_ Panorex X-Ray  
\_\_\_\_\_ Cone Beam X-Ray  
\_\_\_\_\_ Film Processor  
\_\_\_\_\_ Developing Tank  
\_\_\_\_\_  
\_\_\_\_\_

Are X-Ray units Digital? \_\_\_\_\_

**Tanks**

Quantity Acquired   Description

\_\_\_\_\_ Nitrous System  
\_\_\_\_\_ Tank Valves  
\_\_\_\_\_ Air Dryer  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Lab**

Quantity Acquired   Description

\_\_\_\_\_ Model Trimmer  
\_\_\_\_\_ Lathe  
\_\_\_\_\_ Furnace  
\_\_\_\_\_ Splash Hood / Shield  
\_\_\_\_\_ Vibrator  
\_\_\_\_\_ Casting Machine  
\_\_\_\_\_ Suck Down Unit  
\_\_\_\_\_ Articulators  
\_\_\_\_\_ Surveyor  
\_\_\_\_\_ Plaster Bins

**Lab cont'd.**

Quantity Acquired   Description

\_\_\_\_\_ Vacuum Mixer  
\_\_\_\_\_ Lab Handpieces  
\_\_\_\_\_  
\_\_\_\_\_

**Sterilization**

Quantity Acquired   Description

\_\_\_\_\_ Autoclave  
\_\_\_\_\_ Ultrasonic Cleaner  
\_\_\_\_\_  
\_\_\_\_\_

**Hygiene #1**

Quantity Acquired   Description

\_\_\_\_\_ Patient Chair  
\_\_\_\_\_ Dental Units  
\_\_\_\_\_ Doctor's Stool  
\_\_\_\_\_ Assistant's Stool  
\_\_\_\_\_ Light  
\_\_\_\_\_ Mobile Carts  
\_\_\_\_\_ Prophy Jet  
\_\_\_\_\_ Cavitron  
\_\_\_\_\_ High Speed HP  
\_\_\_\_\_ Low Speed HP  
\_\_\_\_\_ Curing Light  
\_\_\_\_\_ X-Ray Units  
\_\_\_\_\_ Computer

**Hygiene #2**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Light
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	Cavitron
_____	_____	_____	High Speed HP
_____	_____	_____	Low Speed HP
_____	_____	_____	Curing Light
_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	_____
_____	_____	_____	_____

**Hygiene #3**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Light
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	Cavitron
_____	_____	_____	High Speed HP
_____	_____	_____	Low Speed HP
_____	_____	_____	Curing Light

**Hygiene #3 cont'd.**

Quantity Acquired   Description

_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	Nitrous Meter
_____	_____	_____	_____
_____	_____	_____	_____

**Hygiene #4**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Light
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	Cavitron
_____	_____	_____	High Speed HP
_____	_____	_____	Low Speed HP
_____	_____	_____	Curing Light
_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	_____
_____	_____	_____	_____

**Operatory #1**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool

**Operator #1 cont'd.**

Quantity Acquired   Description

_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	HS HP's
_____	_____	_____	SS HP's
_____	_____	_____	Electric HP's
_____	_____	_____	Curing Light
_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	Nitrous Meter
_____	_____	_____	Amalgamator
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

**Operator #2**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	HS HP's
_____	_____	_____	SS HP's
_____	_____	_____	Electric HP's
_____	_____	_____	Curing Light

**Operator #2 cont'd.**

Quantity Acquired   Description

_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	Nitrous Meter
_____	_____	_____	Amalgamator
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

**Operator #3**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	HS HP's
_____	_____	_____	SS HP's
_____	_____	_____	Electric HP's
_____	_____	_____	Curing Light
_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	Nitrous Meter
_____	_____	_____	Amalgamator
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	



**Operator #4**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	HS HP's
_____	_____	_____	SS HP's
_____	_____	_____	Electric HP's
_____	_____	_____	Curing Light
_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	Nitrous Meter
_____	_____	_____	Amalgamator
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Operator #5**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet

**Operator #5 cont'd.**

Quantity Acquired   Description

_____	_____	_____	HS HP's
_____	_____	_____	SS HP's
_____	_____	_____	Electric HP's
_____	_____	_____	Curing Light
_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	Nitrous Meter
_____	_____	_____	Amalgamator
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Operator #6**

Quantity Acquired   Description

_____	_____	_____	Patient Chair
_____	_____	_____	Dental Units
_____	_____	_____	Doctor's Stool
_____	_____	_____	Assistant's Stool
_____	_____	_____	Lights
_____	_____	_____	Mobile Carts
_____	_____	_____	Prophy Jet
_____	_____	_____	HS HP's
_____	_____	_____	SS HP's
_____	_____	_____	Electric HP's
_____	_____	_____	Curing Light
_____	_____	_____	X-Ray Units
_____	_____	_____	Computer
_____	_____	_____	Nitrous Meter

**Operatory #6 cont'd.**

Quantity Acquired Description

\_\_\_\_\_ Amalgamator  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Operatory #7**

Quantity Acquired Description

\_\_\_\_\_ Patient Chair  
\_\_\_\_\_ Dental Units  
\_\_\_\_\_ Doctor's Stool  
\_\_\_\_\_ Assistant's Stool  
\_\_\_\_\_ Lights  
\_\_\_\_\_ Mobile Carts  
\_\_\_\_\_ Prophy Jet  
\_\_\_\_\_ HS HP's  
\_\_\_\_\_ SS HP's  
\_\_\_\_\_ Electric HP's  
\_\_\_\_\_ Curing Light  
\_\_\_\_\_ X-Ray Units  
\_\_\_\_\_ Computer  
\_\_\_\_\_ Nitrous Meter  
\_\_\_\_\_ Amalgamator  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Operatory #8**

Quantity Acquired Description

\_\_\_\_\_ Patient Chair  
\_\_\_\_\_ Dental Units  
\_\_\_\_\_ Doctor's Stool  
\_\_\_\_\_ Assistant's Stool  
\_\_\_\_\_ Lights  
\_\_\_\_\_ Mobile Carts  
\_\_\_\_\_ Prophy Jet  
\_\_\_\_\_ HS HP's  
\_\_\_\_\_ SS HP's  
\_\_\_\_\_ Electric HP's  
\_\_\_\_\_ Curing Light  
\_\_\_\_\_ X-Ray Units  
\_\_\_\_\_ Computer  
\_\_\_\_\_ Nitrous Meter  
\_\_\_\_\_ Amalgamator  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are computers networked? \_\_\_\_\_

Is all equipment in working condition? \_\_\_\_\_

If not, describe exceptions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## **Office Layout**

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