IMPORTANT NOTE: This questionnaire is only intended for practice owners seeking our Free Preliminary Consultation. It is not intended for use by those listing their practices for sale with our Company, or those obtaining practice valuations (commonly called “appraisals”) from our Company. This questionnaire does not collect adequate information for practice sale listings or practice valuations. For the appropriate questionnaire for practice sale listings and practice valuations, obtain the Information Collection Questionnaire available in the Forms section of our website, or contact our Company for a copy.

CONFIDENTIALITY: All information that you supply, in response to this Questionnaire, will be treated with the appropriate confidentiality.

INSTRUCTIONS:

1) Please print, or write legibly.

2) For speed and ease, at this preliminary analysis stage, you may estimate answers, rather than have to take the time to research exact numbers, dollar amounts, etc. However, the closer your answers are to the correct amounts, the more accurate our analysis and feedback will be. (If, at a later time, you elect to use our services to assist in the actual execution of your project, we will supply another questionnaire upon which you can then provide exact / accurate answers.)

3) Once complete, you may fax, mail, or scan and e-mail this Questionnaire to the fax number, e-mail address, or mailing address that follows.

Fax: (304) 486-5815

E-mail to: george@gdstollingsassoc.com

Mail: George D. Stollings and Associates, Inc.
RR 2 Box, 329-A,
Prichard, WV 25555
PRACTICE OWNER(S) INFORMATION

Your Name: ______________________ Date: ____________________
Year of dental school graduation? ________
Practice address: ___________________________________________
                      City: __________________     State: _______     Zip: ____________
Office Ph: ___________________________ Office Fax: ______________
Home/evening contact Ph: __________________
Cell Ph: __________________________
E-mail address: ___________________________________________
Do you check e-mails frequently? (___) Yes (___) No
Do you have Microsoft Word Software? ___________ Adobe Acrobat Reader Software? ___________
Home address: ________________________________
City: __________________     State: _______     Zip: ____________

YOUR THOUGHTS & PLANS

Please describe what you would like to accomplish in regards to your practice, when you would like to do so, and describe how you see it unfolding (e.g. structure, timing, role of associates or buyers, etc.). Once we review the information that you provide on this questionnaire, we may suggest different approaches, but we want to make sure that we first understand and consider your objectives and ideas.

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

(Use supplemental pages if more space is needed.)

GENERAL PRACTICE / OFFICE INFORMATION:

For the last two years for which you have filed a tax return, please provide the following:

Most Recent Year – Note The Year: ______
Approximate -- Total Office Collections: $_____________
Approximate -- Your Personal Taxable Income / Profit From The Practice: $_____________

Year Before – Note The Year: ______
Approximate -- Total Office Collections: $_____________
Approximate -- Your Personal Taxable Income / Profit From The Practice: $_____________

Page 2
Last year, approximately how much was produced (fee charges) per year by each of the following?
- You (the practice owner): $__________
- Your associate (if you have one): $__________
- Your hygiene department: $__________
- Total For Entire The Office / Practice: $__________

Square footage of your office suite: __________
Total number of fully equipped operatories: All types: ___ # for Dentists: _____ # for Hygienists ___
Number of operatory rooms available, but not equipped: _____
Average age of your dental equipment: _____ years
Year in which your newest operatory was purchased: _____
Dental equipment is: (__) Right-handed (__) Left-handed (__) Ambidextrous

If you LEASE or RENT YOUR OFFICE SPACE from another party:
- Current monthly rent: $__________
- Years remaining on lease: _______
- Do you have an option to renew? _______ For ___ years. At $_____/mo. Rent.
- Can your lease be assigned to a buyer if you sell your practice? __________

If you OWN YOUR OFFICE SPACE:
- If you sold the building to a practice buyer – the sale price you’d ask? $__________
- If you leased to a practice buyer – the monthly rent you’d ask? $______________
- Which will you require?
  (__) Practice buyer must purchase office building;
  (__) Practice buyer must lease office building; or
  (__) Either of the above.

What do you think is the approximate value of your practice? $______________
How did you determine this, or estimate this dollar value? _______________________

Is money from your future practice sale very important to your retirement plans? (__) Yes (__) No
On what approximate date do you plan to retire or cease private practice? ______________

Is your health insurance provided for you, through a health insurance plan established by your practice’s corporation or limited liability company? (__) Yes (__) No

Until you retire or sell your practice, in regards to your current income:
  (__) I need for my income to increase  (__) I need to maintain my current income level
  (__) I can accept a decline in my income, but need to make at least $______________ per year.

Days and hours office open per week: _________________________________
Is this the same days/hours worked over past 3 years? ____ If not, explain the change, when, and why it occurred: _________________________________
Estimate the percentage of your production & collection that come from each of the following:

- ___% from recall services
- ___% from removable pros.
- ___% from periodontics
- ___% surgery (impactions, etc.)
- ___% TMJ treatment / therapy

- ___% from restorative (fillings)
- ___% simple extractions
- ___% cosmetic dentistry
- ___% surgery (impactions, etc.)
- ___% implant placement

- ___% from crown & bridge
- ___% from endodontics
- ___% orthodontics
- ___% from endodontics
- ___% from periodontics
- ___% from cosmetic dentistry
- ___% from implant placement

- ___% from sedation fees
- ___% Other:

Estimate the percentage of your collections that come from each of the following:

- Capitation / HMO / DMO / Managed Care contracts: ___%
- PPO’s, including Delta Dental: --------------------- ___%
- Medicaid: -------------------------- ___%
- Standard Indemnity Insurance: ---------------------- ___%
- Patient Payments: --------------------------- ___%

Estimate average number of new patients seen per month: ______

Estimate of the number of recall patients seen in last 6 months: ______

How far ahead, in weeks, is your personal appointment schedule booked? _____ wks

Average number of patients you personally see per work day (exclude hygiene): ______

Please fill-out the following in regards to your hygienists:

<table>
<thead>
<tr>
<th>Hygienist</th>
<th>Days Per Week</th>
<th>Hours Per Day</th>
<th>Average # Patients Seen Per Work Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>______</td>
<td>_____</td>
<td>______</td>
</tr>
<tr>
<td>#2</td>
<td></td>
<td>_____</td>
<td>______</td>
</tr>
<tr>
<td>#3</td>
<td></td>
<td></td>
<td>______</td>
</tr>
</tbody>
</table>

Number of front desk employees: ______  Number of expanded duty assistants: ______

Number of full-time standard assistants: ______  Number of part-time standard assistants: ______

RE: New Technologies in Your Practice (check applicable spaces):

- (____) Digital X-ray - (____) Sensors - (____) or (____) Phosphorus plates
- (____) Cerec - (____) Used regularly -- or -- (____) Used infrequently
- (____) Intra-oral camera - (____) Used regularly -- or -- (____) Used infrequently
- (____) Computer charting
- (____) Computers in all operatories, networked
- (____) Laser - (____) Used regularly -- or -- (____) Used infrequently
  - Type of laser: ____________________________
  - Used for what procedures? __________________
- (____) ZOOM - (____) Used regularly -- or -- (____) Used infrequently

Is your practice “amalgam free”? (____) Yes (____) No  Comment: ____________________________
What are your standard fees for?

- Crown $________
- Panoramic x-ray $________
- Adult Prophy $________
- 3 Surface Amalgam $________
- 3 Surface posterior composite $________
- Single canal root canal $________

Do you have a second satellite office? (__) Yes (__) No --- If “Yes”, how far from this office is that satellite office located? ____________ miles

Does your practice have a website? (__) Yes (__) No – If “Yes”, please provide the website address: www. ______________________________

What factors have affected your practice, positively or negatively, in the past five (5) years?

_________________________________________________________________________________________________________________

Are special skills required to provide the treatment that you provide? _____ If so, please describe: ________________________________________________________________________

Total length of time in practice: ___________ At this specific office / location: _____________

Do you depend on advertising to sustain patient flow, new patient influx, and production? ____
If “Yes”, describe your advertising: ___________________________________________________________________________________

If you have loans or debts on the practice or its assets (equipment, etc.), or personal loans for which practice assets were used as collateral, please note them below. For each, please provide the following:

<table>
<thead>
<tr>
<th>Lender / Bank Name</th>
<th>Amount Still Owed</th>
<th>Monthly Payment</th>
<th>Years Left On Loan</th>
<th>What items are collateral for this loan? (What are liens placed on?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loan 1</td>
<td>$_________</td>
<td>$_________</td>
<td>_____ yrs.</td>
<td>____________________________</td>
</tr>
<tr>
<td>Loan 2</td>
<td>$_________</td>
<td>$_________</td>
<td>_____ yrs.</td>
<td>____________________________</td>
</tr>
<tr>
<td>Loan 3</td>
<td>$_________</td>
<td>$_________</td>
<td>_____ yrs.</td>
<td>____________________________</td>
</tr>
<tr>
<td>Loan 4</td>
<td>$_________</td>
<td>$_________</td>
<td>_____ yrs.</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

If your plan is to sell your practice:
Will you work after sale, to assist transition? __________________ For how long? ________________
Is it mandatory that you stay on to work? (__) Yes (__) No
If “Yes” – how many days per week do you want to work? ________ / wk
If “Yes” – what minimum annual income do you want to maintain? $___________

Do you have any health, illness, or any disability conditions that could result in a production decline? ____________________________________________________________________

Have there been any EPA problems, investigations, or is there anything else that indicates the possibility of environmental problems in or around your facility? ______
Have there been any law suits/legal actions relative to your practice in the past 5 years? ________ If so, please explain: _____________________________________________________________

Have there been any dental board investigations or actions in the last 5 years? _______ If so, please explain: _____________________________________________________________

Have you suffered any bad publicity for any reason in the past 5 years? ______ If so, please explain: _____________________________________________________________

Are there any factors (your community, the economy, with your practice or staff, or any aspect of your operation, etc.) that would, or could cause your practice operating and financial results in the future to vary from those obtained last year? ________
If yes, explain: __________________________________________________________________________

Which best describes your office location?
( ) Inner city  ( ) urban  ( ) Suburban  ( ) Small City ( ) Small town ( ) Rural

Describe the neighborhood in which your practice is located? ________________________________
____________________________________________________________________________________

INFORMATION ABOUT YOUR CURRENT DENTAL ASSOCIATE

Skip this section if you do not currently have an employed (or independent contractor) dental associate.

1) Describe the formula used to pay your associate: __________________________________________

2) Days and hours each day that your associate works: _________________________________________

3) Associate's Income:  
   Last Year: $ ________
   Year Before Last: $ __________

4) How long has he / she worked in your practice? ______

5) Approximately what were the total annual collections of the practice before the associate joined your practice? $___________

6) What do you think are your associate’s career and financial goals for the next 5 to 10 years? __________________________________________________________

7) Associate’s age? ______ yrs.

8) Does your associate work under a written and signed employment or independent contractor agreement (contract)? ( ) Yes ( ) No
   a. If yes, does it contain a restrictive covenant (non-compete) agreement ( ) Yes ( ) No
   b. If it does:
      i. How many miles? ______
      ii. How many years? ______
Thank You For Taking Time To Complete This Questionnaire

After reviewing the information that you have provided in this Questionnaire, and taking time to give consideration to it, I look forward to communicating with you to share my thoughts on, and recommendations for your project.

Regards,

George D. Stollings, D.D.S.
For: George D. Stollings and Associates, Inc.