

# PRELIMINARY PRACTICE SALE CONSULTATION QUESTIONNAIRE

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**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.

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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:

- o Current monthly rent: \$ \_\_\_\_\_
- o Years remaining on lease: \_\_\_\_\_
- o Do you have an option to renew? \_\_\_\_\_ For \_\_\_\_ years. At \$\_\_\_\_\_/mo. Rent.
- o Can your lease be assigned to a buyer if you sell your practice? \_\_\_\_\_

If you OWN YOUR OFFICE SPACE:

- o If you sold the building to a practice buyer – the sale price you'd ask? \$ \_\_\_\_\_
- o If you leased to a practice buyer – the monthly rent you'd ask? \$ \_\_\_\_\_
- o 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 restorative (fillings)                       % from crown & bridge
- % from removable pros.                       % simple extractions                       % from endodontics
- % from periodontics                       % cosmetic dentistry                       % implant placement
- % surgery (impactions, etc.)                       % orthodontics                       % implant restoration
- % TMJ treatment / therapy                       % 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:

Hygienist	Days Per Week	Hours Per Day	Average # Patients Seen Per Work Day
#1	_____	_____	_____
#2	_____	_____	_____
#3	_____	_____	_____

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 \$ \_\_\_\_\_

Adult Prophy \$ \_\_\_\_\_

3 Surface posterior composite \$ \_\_\_\_\_

Panoramic x-ray \$ \_\_\_\_\_

3 Surface Amalgam \$ \_\_\_\_\_

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:

Lender / Bank Name	Amount Still Owed	Monthly Payment	Years Left On Loan	What items are collateral for this loan? (What are liens placed on?)
Loan 1 _____	\$ _____	\$ _____	_____ yrs.	_____
Loan 2 _____	\$ _____	\$ _____	_____ yrs.	_____
Loan 3 _____	\$ _____	\$ _____	_____ yrs.	_____
Loan 4 _____	\$ _____	\$ _____	_____ yrs.	_____

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.*

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