

# DENTAL PRACTICE PROFILE

The information requested in this profile is required for the completion of your practice analysis and practice valuation. Please complete this profile as thoroughly as possible and provide all of the requested support documentation. We need detailed and precise information so that we can produce a meaningful and accurate analysis and appraisal for you.

Please send the required documents listed on page 19 of this profile and this completed and signed profile to your PARAGON consultant:



## PERSONAL INFORMATION

Name (please include degree) \_\_\_\_\_

Corporate (LLC) Name (if applicable) \_\_\_\_\_

Email address: \_\_\_\_\_

Website Address: \_\_\_\_\_

Practice Type:  General  Specialty \_\_\_\_\_

Send mail to:  Home  Office

Office Address \_\_\_\_\_

\_\_\_\_\_ Zip Code \_\_\_\_\_

County / Parish: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_ FAX: \_\_\_\_\_

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

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

\_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

I am:  right-handed  left-handed

My health is:  excellent  good  fair

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Children (ages & names) \_\_\_\_\_

Hobbies & Interests \_\_\_\_\_

Names of Study Clubs \_\_\_\_\_

Offices Held \_\_\_\_\_

## ADVISORS

Attorney \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Accountant \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Financial Planner \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

Bank \_\_\_\_\_ Contact \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_

Other \_\_\_\_\_ Phone \_\_\_\_\_ FAX \_\_\_\_\_

## PROFESSIONAL

Dental School \_\_\_\_\_ Graduated \_\_\_\_\_  
Post-graduate \_\_\_\_\_ Completed \_\_\_\_\_  
State Licenses currently held \_\_\_\_\_  
Organization \_\_\_\_\_ Office \_\_\_\_\_  
Residencies \_\_\_\_\_ Year \_\_\_\_\_ thru \_\_\_\_\_  
Other post-graduate training \_\_\_\_\_

## PRACTICE SALE INFORMATION

If you are selling or thinking about selling your practice, please answer the following questions. If you are not considering selling, please continue completing this profile with "The Practice" section on page 5.

Reason for analysis / appraisal \_\_\_\_\_

Reason for selling \_\_\_\_\_  
\_\_\_\_\_

What are your post-sale plans? \_\_\_\_\_  
\_\_\_\_\_

Would you like to practice dentistry in another area? .....  Yes  No

If yes, where? \_\_\_\_\_

Would you like to continue practicing in this practice after the sale? .....  Yes  No

How many days per week? \_\_\_\_\_ For how many more years? \_\_\_\_\_

Have you ever tried to sell your practice before? .....  Yes  No

Have you spoken to another organization about selling? .....  Yes  No

Name of organization \_\_\_\_\_

Has your practice been listed for sale with another firm? .....  Yes  No

When did you list? \_\_\_\_\_ Asking price \$ \_\_\_\_\_

Why do you think it did not sell? \_\_\_\_\_

Is another firm attempting to sell your practice now? .....  Yes  No

If yes, what firm? \_\_\_\_\_

Is your staff aware of your desire to sell? .....  Yes  No

Are any of your colleagues aware that your practice is for sale? .....  Yes  No

Do you own any other practices in the area? .....  Yes  No

If yes, how many? \_\_\_\_\_

If yes, how close are those practices to this practice? \_\_\_\_\_

If yes, do you have employees/providers working in this practice as well as others? .....  Yes  No

Please list those dentists who you would like us to confidentially contact on your behalf and also those dentists you prefer for us not to contact.

Contact

Do Not Contact

_____	_____
_____	_____
_____	_____
_____	_____

## DEMOGRAPHICS AND POPULATION

Mark the one characteristic that most closely describes the area where your office is located:

- |   |                                     |                                      |
|---|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Downtown Business District | <input type="checkbox"/> Inner City | <input type="checkbox"/> Resort Area |
| <input type="checkbox"/> Urban                      | <input type="checkbox"/> Suburban   | <input type="checkbox"/> Rural       |

Describe your local population:       increasing     decreasing     stable     transient

Estimate the percentage of applicable income for your office area:

High-income \_\_\_\_\_%    Middle-income \_\_\_\_\_%    Low-income \_\_\_\_\_%

Specialists ONLY: How many competitive practices are within a 5-mile radius? ..... \_\_\_\_\_

The office is located in a:

- |   |  |                                |
|---|--|--------------------------------|
| <input type="checkbox"/> Multi-tenant building  | <input type="checkbox"/> Shopping Center         | <input type="checkbox"/> Mall  |
| <input type="checkbox"/> Free standing building | <input type="checkbox"/> Office Condo or Complex | <input type="checkbox"/> Other |

The building is a .....  Single story     Two story     Hi / Mid Rise

Traffic volume is .....  High     Medium     Low

Access from road to parking area .....  Excellent     Good     Poor

Parking is .....  Free     Paid     N/A

Is public transportation available? .....  Yes     No

## MAJOR EMPLOYERS

Name \_\_\_\_\_ Insurance? .....  Yes     No

Name \_\_\_\_\_ Insurance? .....  Yes     No

Name \_\_\_\_\_ Insurance? .....  Yes     No

Have any major employer changes occurred in the past three years? .....  Yes     No

If yes, please explain \_\_\_\_\_

Any major employer changes anticipated? .....  Yes     No

If yes, please explain \_\_\_\_\_

## BUILDING AND REAL ESTATE

Complete this section of you own the building.

Overall condition of building .....  Excellent       Good       Poor

If Poor, please explain \_\_\_\_\_

Do you own the office building? .....  Yes       No

If Yes: Total sq. ft. of entire building      Lot size \_\_\_\_\_

Year built      Original Cost \$      Current Value \$ \_\_\_\_\_

Current Mortgage Balance \$      Monthly Payment \$ \_\_\_\_\_

Total sq. ft. of dental office      Located on which floor? \_\_\_\_\_

Does the building have an elevator? .....  Yes       No

Year built      Year remodeled      should rent for \$ \_\_\_\_\_ / month

## OFFICE LEASE

Complete this section of you DO NOT own the building.

**Please provide a copy of your current lease agreement.**

Overall condition of office .....  Excellent       Good       Poor

Who is your landlord? \_\_\_\_\_

Contact      Phone Number \_\_\_\_\_

When does your current lease expire? \_\_\_\_\_

How much do you pay each month for rent? ..... \$ \_\_\_\_\_

Total square feet of the office? ..... \_\_\_\_\_

Does the monthly rent include utilities? .....  Yes       No

If No, what is the approximate amount of your monthly utilities? ..... \$ \_\_\_\_\_

Does the monthly rent include janitorial / maid services? .....  Yes       No

Do you have an option to renew the lease? .....  Yes       No

If yes, for how many more years after this current lease expires? \_\_\_\_\_

Monthly rent amount upon renewal (if applicable)? ..... \$ \_\_\_\_\_

Do you have an option to purchase the building? .....  Yes       No

Purchase option amount (if applicable)? \$      Option date? \_\_\_\_\_

Can you assign this lease? .....  Yes       No

Will the landlord allow the lease to be transferred? .....  Yes       No

Do you like your office space? .....  Yes       No

## OFFICE FACILITY USAGE

Total number of equipped operatories? .....

Number of operatories used by doctors? \_\_\_\_\_ Used by hygienists? \_\_\_\_\_

Do you have any partially equipped operatories in your office? .....  Yes  No

If yes, how many? .....

Do you have any empty, non-equipped rooms in your office? .....  Yes  No

If yes, how many? .....

Are any of these non-equipped rooms plumbed? .....  Yes  No

If Yes, how many? .....

Do you have any plans for additional rooms? .....  Yes  No

If yes, please explain \_\_\_\_\_

Check the rooms you have in your office:

- |  |   |                                     |
|--|---|-------------------------------------|
| <input type="checkbox"/> Business Office                       | <input type="checkbox"/> Private Office | <input type="checkbox"/> X-ray room |
| <input type="checkbox"/> Consultation Rooms # _____            | <input type="checkbox"/> Staff Lounge   | <input type="checkbox"/> Dark room  |
| <input type="checkbox"/> Sterilization room                    | <input type="checkbox"/> Laboratory     | <input type="checkbox"/> Mechanical |
| <input type="checkbox"/> Reception seating for _____ patients. | <input type="checkbox"/> Other _____    |                                     |

## THE PRACTICE

Does the practice operate as a Limited Liability Company (LLC, PLLC, etc)? .....  Yes  No

If so, did you elect to be taxed as a corporation? .....  Yes  No

Did you purchase the practice? .....  Yes  No

Date practice was established \_\_\_\_\_ Date you acquired practice \_\_\_\_\_

Do you own 100% of this practice? .....  Yes  No

If No, what percentage do you own? ..... %

Type of practice:  Solo  Group  Retail Clinic  Other \_\_\_\_\_

How many doctors are practicing in the office? .....

Do you have an associate? .....  Yes  No

Is your associate practicing under a written contract? .....  Yes  No

Does the associate contract include a restrictive covenant? .....  Yes  No

If yes, how many miles does it cover? \_\_\_\_\_ For how many years? \_\_\_\_\_

Does your associate also work in other practices you own?.....  Yes  No

Have you ever hired an associate in the past? .....  Yes  No

If Yes, when? \_\_\_\_\_ Why did the associate leave? \_\_\_\_\_

Do you have a satellite office? .....  Yes  No

Date satellite was established \_\_\_\_\_ Date you acquired satellite \_\_\_\_\_

Are you employed in any other professional facility?.....  Yes  No

If Yes, how many miles is the location from your current office \_\_\_\_\_

Do your practice gross revenues include payments received at another office? .....  Yes  No

If Yes, how much is included in the last complete financial year provided? ..... \$ \_\_\_\_\_

What percentage of the practice income is from Capitation / P.P.O. patients? ..... \_\_\_\_\_%

How many weeks vacation do you take per year?..... \_\_\_\_\_

General practice ONLY: Do you have a specialist treat patients in your office? .....  Yes  No

If Yes, what specialties?\_\_\_\_\_

Does the practice have an amalgam separator?.....  Yes  No

Is the practice an amalgam-free practice? .....  Yes  No

Do you provide nitrous oxide? (Approximate percent of patients \_\_\_\_\_%) .....  Yes  No

Do you provide IV sedation? (Approximate percent of patients \_\_\_\_\_%) .....  Yes  No

Do you provide conscious sedation? (Approximate percent of patients \_\_\_\_\_%) .....  Yes  No

Has your practice or you ever been involved in any legal/board actions? .....  Yes  No

If yes, explain \_\_\_\_\_

Is your practice an ALL CASH practice? .....  Yes  No

Do you offer patient credit? .....  Yes  No

Payments accepted:  Credit Cards  Insurance accepted  Other \_\_\_\_\_

Do you accept Medicaid? (Approximate percent of patients \_\_\_\_\_%).....  Yes  No

Specialty work referred:  Perio  Ortho  Pedo  Endo  Prostho  OS  Other \_\_\_\_\_

Specialty work provided:  Perio  Ortho  Pedo  Endo  Prostho  OS  Other \_\_\_\_\_

Is your office computerized? .....  Yes  No

If yes, to what extent?  limited usage  front-office only  fully computerized office

Describe computer equipment & software: \_\_\_\_\_

\_\_\_\_\_

## PATIENT INFORMATION

How many patients does your practice treat in a typical day?..... \_\_\_\_\_

Are you a provider in any prepaid plans, reduced fee PPO or other plans?.....  Yes  No

If yes, specify \_\_\_\_\_ Transferable?.....  Yes  No

**THE ACTIVE PATIENT COUNT IS VERY IMPORTANT: If you do not know exactly how many patients you have you can estimate by counting the number of records in your files that represents one foot of file space (typically approximately 60 records) and then multiply the number of patients counted in that one foot by the total number of feet of active files.**

Number of active patients? (*Patients treated in past 24 months*) ..... \_\_\_\_\_

Number of Fee-For-Service patients \*

\* includes PPO & Insurance paying 90% or more of your customary fees ..... \_\_\_\_\_

Number of Non-Capitation, Plan patients \*\*

\*\* includes PPO & Ins. paying less than 90% of your customary fees ..... \_\_\_\_\_

Number of Capitation patients? \_\_\_\_\_ Monthly Income Per CAP Patient ..... \$\_\_\_\_\_

When did you last update your patient files? ..... \_\_\_\_\_

Estimated patient mix: high-income \_\_\_\_\_% middle-income \_\_\_\_\_% low-income \_\_\_\_\_%

Estimated patient mix: under age 16 \_\_\_\_\_% 16 to 35 \_\_\_\_\_% 35 to 55 \_\_\_\_\_% over 55 \_\_\_\_\_%

Average number of new patients your practice receives each month?..... \_\_\_\_\_

New patient source breakdown: \_\_\_\_\_ % from Advertising \_\_\_\_\_ % from Walk-ins  
\_\_\_\_\_ % from Patient referrals \_\_\_\_\_ % from PPO plans  
\_\_\_\_\_ % from Professional referrals \_\_\_\_\_ % from Capitation

Do you have new patient internal and external marketing programs? .....  Yes  No

Advertising:  Yellow pages  Newspaper  Mailings  Newsletter  Other

Other marketing efforts \_\_\_\_\_

Do you have an active patient recall system? .....  Yes  No

Do you pre-appoint patients? .....  Yes  No

Do you have an office policy for large case treatment plans? .....  Yes  No

Do you have an office policy for patient financial arrangements? .....  Yes  No

Approximate number of weeks YOU are booked in advance?..... \_\_\_\_\_

Average time to work a new patient into YOUR schedule?..... \_\_\_\_\_

How long do you allow for a new patient initial appointment? ..... \_\_\_\_\_

As a general rule, who is the first to treat new patients in your office? .....  Doctor  Hygienist

## OFFICE HOURS

### Main Office Hours

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

### Satellite Office Hours

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

## HYGIENE

Do you have a formal hygiene program? .....  Yes  No

Number of hygienists employed? ..... Full time \_\_\_\_\_ Part time \_\_\_\_\_

Number of days each hygienist works? ..... Full time \_\_\_\_\_ Part time \_\_\_\_\_

Average number of patients each treats daily? ..... Full time \_\_\_\_\_ Part time \_\_\_\_\_

Number of hygiene days per week? (2 hygienists working 4 days each equals 8 hygiene days) ..... \_\_\_\_\_

Number of hygiene patients treated in your practice per week? ..... \_\_\_\_\_

Weeks hygiene is booked in advance? ..... \_\_\_\_\_

Estimated number of weeks required to work in a new hygiene patient? ..... \_\_\_\_\_

Do you have a formal soft tissue management program? .....  Yes  No

Do you maintain waiting list for patients awaiting hygiene treatment? .....  Yes  No

## FINANCIAL INFORMATION

**TOTAL PRACTICE:** "Net Production", "Collections" and "Lab Fees" for each of the past 3 years

Year \_\_\_\_\_ Production \$ \_\_\_\_\_ Collections \$ \_\_\_\_\_ Lab fees \$ \_\_\_\_\_

Year \_\_\_\_\_ Production \$ \_\_\_\_\_ Collections \$ \_\_\_\_\_ Lab fees \$ \_\_\_\_\_

Year \_\_\_\_\_ Production \$ \_\_\_\_\_ Collections \$ \_\_\_\_\_ Lab fees \$ \_\_\_\_\_

**HYGIENE ONLY:** "Net Production" and "Collections" for each of the past 3 years

Year \_\_\_\_\_ Production \$ \_\_\_\_\_ Collections \$ \_\_\_\_\_

Year \_\_\_\_\_ Production \$ \_\_\_\_\_ Collections \$ \_\_\_\_\_

Year \_\_\_\_\_ Production \$ \_\_\_\_\_ Collections \$ \_\_\_\_\_

## GENERAL PRACTICE INFORMATION

What average lab cost do you pay for a Porcelain to Precious Metal crown? ..... \$ \_\_\_\_\_

What is your outstanding Accounts Receivable balance? ..... \$ \_\_\_\_\_

Percentage of Accounts Receivable balance that is insurance? ..... %

Percentage of Accounts Receivable balance that is 90 days or older? ..... %

Balance of your outstanding practice loans or equipment leases? (submit detail) ..... \$ \_\_\_\_\_

Do you provide Orthodontic services? .....  Yes  No

If Yes, what is the dollar value of the existing orthodontic contracts? ..... \$ \_\_\_\_\_

## PERSONNEL

	NAME	ANNUAL SALARY OR COMMISSION	YEARS EMPLOYED	ANNUAL GROSS PRODUCTION
Owner Doctor #1	_____	\$ _____	_____	\$ _____
Owner Doctor #2	_____	\$ _____	_____	\$ _____
Owner Doctor #3	_____	\$ _____	_____	\$ _____
Associate #1	_____	\$ _____	_____	\$ _____
Associate #2	_____	\$ _____	_____	\$ _____
Hygienist #1	_____	\$ _____	_____	\$ _____
Hygienist #2	_____	\$ _____	_____	\$ _____
Hygienist #3	_____	\$ _____	_____	\$ _____
Hygienist #4	_____	\$ _____	_____	\$ _____
Front Office #1	_____	\$ _____	_____	
Front Office #2	_____	\$ _____	_____	
Front Office #3	_____	\$ _____	_____	
Front Office #4	_____	\$ _____	_____	
Assistant #1	_____	\$ _____	_____	
Assistant #2	_____	\$ _____	_____	
Assistant #3	_____	\$ _____	_____	
Assistant #4	_____	\$ _____	_____	
Hygiene Assistant	_____	\$ _____	_____	

Have you had an employee recently (less than 1 year) leave your practice? .....  Yes  No

Does your spouse work in the practice? .....  Yes  No

If so, in what capacity? \_\_\_\_\_

Does your spouse receive a salary? .....  Yes  No

If so, what is spouse's annual salary? ..... \$ \_\_\_\_\_

Do you use expanded duty personnel? .....  Yes  No

Do you have part-time hygienists who also work in other practices in the area? .....  Yes  No

## OSHA COMPLIANCE

- Are your tray set-ups autoclaved after every patient? .....  Yes  No
- Can your handpieces be put in the autoclave?.....  Yes  No
- Has all of your staff been trained in accordance with OSHA/CDC guidelines? .....  Yes  No
- Has all of your staff been immunized against Hepatitis B?.....  Yes  No
- Do you and staff wear gloves, masks and protective eyewear for every patient?.....  Yes  No
- Do you have a written Hazard Communication Manual? .....  Yes  No
- Has your staff been trained in the handling of the chemicals used in your office?.....  Yes  No
- Do you have Material Safety Date Sheets (MSDS) for all dental materials used?.....  Yes  No

## FEE SCHEDULE

Please either complete the fee schedule below or attach a copy of your full fee schedule.

D2750	Crown - Porcelain to high noble metal.....	\$ _____
D2950	Crown - build-up with pins.....	\$ _____
D2920	Crown - recement.....	\$ _____
D3310	Root Canal - 1 canal.....	\$ _____
D3320	Root Canal - 2 canals.....	\$ _____
D3330	Root Canal - 3 canals.....	\$ _____
D2140	Amalgam - 1 surface (primary or permanent).....	\$ _____
D2150	Amalgam - 2 surfaces (primary or permanent).....	\$ _____
D2160	Amalgam - 3 surfaces (primary or permanent).....	\$ _____
D2330	Resin based composite - 1 surface (anterior).....	\$ _____
D2331	Resin based composite - 2 surfaces (anterior).....	\$ _____
D2391	Resin based composite - 1 surface (posterior).....	\$ _____
D2392	Resin based composite - 2 surface2 (posterior).....	\$ _____
D2393	Resin based composite - 3 surfaces (posterior).....	\$ _____
D7140	Extraction (removal and closure).....	\$ _____
D0120	Periodic Oral Exam.....	\$ _____
D0150	Comprehensive Oral Evaluation.....	\$ _____
D0210	Intraoral - complete with bitewings.....	\$ _____
D0272	Bitewing - 2 films.....	\$ _____
D0330	Panoramic film.....	\$ _____
D1110	Prophy - Adult.....	\$ _____
D1120	Prophy - Child.....	\$ _____
D1203	Fluoride - Child.....	\$ _____
D1351	Pit & Fissure Sealant.....	\$ _____
D4341	Perio scaling & root planing (per quadrant).....	\$ _____
D5110	Complete Upper Denture.....	\$ _____
D5120	Complete Lower Denture.....	\$ _____
D9972	External Bleaching (per arch).....	\$ _____

Date of last fee increase \_\_\_\_\_

## EQUIPMENT LIST

Please either provide a typed room-by-room list of equipment and furniture, by manufacturer name and model number OR complete the Equipment List Schedule below. We do not require the cost of the equipment. We also do not need an inventory of your instruments and supplies.

### Reception Area

quantity	description	excellent	good	poor	personal	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Waiting Room Chairs
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tables
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lamps
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### Business Office

quantity	description	excellent	good	poor	personal	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Business Office Desk
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Business Office Chair
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	File Cabinets
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Copy Machine
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Computer
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Printers
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Telephone System
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### Private Office

quantity	description	excellent	good	poor	personal	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office Desk
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office Desk Chair
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Guest Chair
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Book Case
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### Staff Lounge

quantity	description	excellent	good	poor	personal	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Refrigerator
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Table & Chairs
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Microwave
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### X-Ray Equipment

quantity	description	excellent	good	poor	personal	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panorex X-Ray
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Film Processor
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developing Tank
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



**Room #1**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #2**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #3**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #4**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #5**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #6**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #7**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #8**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #9**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Room #10**    **Doctor**    **Hygiene**

<i>quantity</i>	<i>description</i>	<i>excellent</i>	<i>good</i>	<i>poor</i>	<i>personal</i>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient Chair
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Units
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Doctor's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assistant's Stool
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lights
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobile Carts
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prophy Jet
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Speed HP
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Handpieces
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curing Light
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cabinets
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Unit
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray View Box
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Flow Meter
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amalgamator
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



## CHECKLIST OF ITEMS REQUIRED

- Last 3 years tax returns for the practice with detailed expense exhibits.
- A Profit & Loss (Income & Expense) statement for the exact same 12 month period as the most current tax return provided.
- A Profit & Loss (Income & Expense) statement for the most recent 12 months.
- A copy of any current associate agreements and/or employment agreements.
- A copy of the lease on your office facility (if applicable).
- A breakdown of your total expenditures for **INSURANCE** (see questionnaire on next page). Please tell us what types of insurance policies you are paying premiums on (malpractice, office, life, disability, health, etc.) and the amount of each premium that was paid for you personally, your spouse, your children and your employees.
- A breakdown of your **PENSION / PROFIT SHARING** contributions (see questionnaire on next page). Please tell us how much of the total contribution was paid for you, your spouse, your children and your employees.
- A breakdown of expenditures for **TAXES & LICENSES** (see questionnaire on next page). Please tell us how much of the total is for payroll taxes, real estate taxes, personal property taxes, other taxes, licenses, etc. and how much of each expense category was paid for the benefit of the office, for you personally, your spouse, your children, your employees, etc.
- Detailed explanation of your total expenditures for **EMPLOYEE BENEFITS** (see questionnaire on next page). Please tell us how much of the total expense charged to Employee Benefits was paid for the benefit of you personally, your spouse, your children, your employees, etc.
- Interior and exterior office photos (optional).
- A copy of your current fee schedule.
- A detailed explanation of any legal proceedings (including but not limited to any felony convictions), dental board actions and/or drug related issues concerning you and/or your practice. (If none, please initial here \_\_\_\_\_).
- A "production-by-procedure code" report for the year corresponding to your most recent tax return submitted. We are looking for a breakdown of the procedures your practice provided and how much was provided by each provider (you, your associate, your hygienist, etc).
- Financial Analysis Fee (your PARAGON consultant will explain this fee to you).

## DETAILS OF EXPENSE ITEMS

Please provide as much detail as possible so that we may determine how much of these expenditures are for the benefit of your staff and how much are for you and/or your immediate family members (even if your family members are also staff members). Typically either your bookkeeper or your accountant will be able to quickly answer these questions.

**PLEASE READ:** The expense totals provided below MUST RECONCILE back to the exact totals on the financial documentation you are using. The expense Grand Totals entered below reconcile to the:

**IRS Tax Return**       **Profit & Loss Statement (Income & Expense Statement)**

Grand total of **INSURANCE** expense? ..... \$ \_\_\_\_\_

How much of the grand total is for **office facility related insurance**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

How much of the grand total is for **malpractice insurance**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

How much of the grand total is for **life insurance**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

How much of the grand total is for **disability insurance**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

How much of the grand total is for **health insurance**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

Grand total of **PENSION / PROFIT SHARING** expense? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? ..... \$ \_\_\_\_\_

Grand total of **EMPLOYEE BENEFITS** expense? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? ..... \$ \_\_\_\_\_

Grand total of **TAXES & LICENSES** expense? ..... \$ \_\_\_\_\_

How much of the grand total is for **real estate taxes**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

How much of the grand total is for **payroll taxes**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

How much of the grand total is for **property taxes**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

How much of the grand total is for **other taxes**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

How much of the grand total is for **licenses**? ..... \$ \_\_\_\_\_

How much of the total on the line above is exclusively for you or your family? .... \$ \_\_\_\_\_

## PERSONAL DISCLOSURES

Have you ever been convicted of a felony? .....  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had your dental license suspended or revoked? .....  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever been sanctioned by any dental regulatory authority? .....  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Please tell us anything else (regardless of how insignificant it may seem) that could possibly be considered detrimental to the practice including, but not limited to, any information at all pertaining to you or the practice that one would consider significant in making an informed decision about purchasing (either in part or full) the practice (use back or additional pages if needed):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PERSONAL ACKNOWLEDGMENT (please sign below)

*The undersigned acknowledges and agrees that any and all information provided to the undersigned by PARAGON shall be kept confidential and agrees not to disclose to anyone, or make copies of any of the information; ideas; procedures; practices, programs; concepts; contracts; and/or any other tangible data conveyed and entrusted to the undersigned without the prior written consent of PARAGON. In addition, the undersigned hereby certifies that the information provided herein is, to the best of the undersigned's knowledge, completely true and accurate. The undersigned also acknowledges that any information about the practice and/or the undersigned that could be construed by a reasonable person to be detrimental to the practice has been fully disclosed in this Dental Practice Profile. The undersigned further acknowledges that the completion of this Dental Practice Profile and the providing of any additional information required herein shall not be construed, in any manner, to be an offer by PARAGON to sell and/or otherwise convey or transition the undersigned's practice and shall not be construed, in any manner, to be an agreement by the undersigned to allow PARAGON to represent the undersigned in the sale of the undersigned's practice.*

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

Please tell us how you discovered PARAGON: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_