

SELLER QUESTIONNAIRE

Please complete and return to:

Practice Impact, Inc.

5071 Forest Drive, Suite A

New Albany, Ohio 43054

Phone: (800) 735-5336

Fax: (614) 939-4705

Personal Information:

Full Name:			
Home Address:			
E-mail address:			
Home Phone:	()	Cell Phone:	()
Work Phone	()	May we call you at work?	

Educational Information:

	<i>Institution</i>	<i>Degree</i>	<i>Year</i>
Dental School			
Advanced Education			
Residency Program			

Practice Information:

What is the purpose of the appraisal?	
If Selling, what is the reason for the sale?	
Type of Practice:	
Type of Entity:	
If you are a partnership, how many partners do you have?	
City & State Practice is Located in:	
How long have you been at this location?	
Do you own the real estate?	
If building is leased, monthly rental amount:	
Total Square Footage:	
Number of Operatories:	
Do you have more than one office location?	
Number of Hygienists:	

Number of Hygiene Days per week:	
Number of Associates:	
Number of Associate Hours per week:	
Your number of clinical hours per week:	
Most recent annual practice gross:	
Percentage of Managed Care:	
Percent of Medicaid:	
Approximate total number of active patients (in the last 18 months):	
Are you computerized?	
Software used:	