SELLER QUESTIONNAIRE

Please complete and return to:

Practice Impact
"Making Practice Transitions Painless"

5071 Forest Drive, Suite A • New Albany, Ohio 43054
1.800.735.5336 • info@practiceimpact.com
www.practiceimpact.com
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:

	Institution	*Degree*	*Year*
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:	