JPA DENTAL TRANSITIONS

Practice Contact Information

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Practice Backline: _____

Practice Fax: _____

Owner Contact Information

Owner Doctor: _____

Owner Graduation Year: _____

Owner School: _____

Current State License(s) and Number(s): _____

Owner Address: _____

Owner Home Phone: _____ Cell Phone: _____

Owner Email: _____

Owner spouse name: _____

Sale Information

Describe your hopes, goals, and purpose for your transition and after:

Describe any concerns you have regarding your transition:

Projected time period to leave (transition): _____

Owner to Work after sale? If so how many days/week: _____

Percentage of Seller Financing Available for Practice: _____%

Percentage of Seller Financing Available for Real Estate: _____%

Is Seller financially independent to retire? _____

Are there any Seller health issues? _____

Advisor Information:

CPA Name: _____

CPA Company: _____

CPA Address: _____

CPA Phone: _____ CPA Fax: _____

CPA Email: _____

Attorney Name: _____

Attorney Firm: _____

Attorney Address: _____

Attorney Phone: _____ Attorney Fax: _____

Attorney Email: _____

Practice Management Consultant: _____

Consultant Company: _____

Consultant Address: _____

Consultant Phone: _____ Consultant Fax: _____

Consultant Email: _____

Date Consultant last in office: _____

Practice Information

Form of Business:

☐S-Corp ☐C-Corp ☐(P)LLC ☐Sole Proprietor

Date Entity Formed: _____

Recent 12 Month Production:

Owner Production: _____
Associate Production: _____
Hygiene Production: _____
Total Production: _____

Estimated Number of Active Patients in last 18 months:_____

Busyness of Hygiene: ☐ Less than 1 week ☐ 1-2 Weeks ☐ 3-4 Weeks ☐ >4 Weeks

Percentage of patient base paying Cash	
Percentage of patient base with insurance	
Percentage of patient base from PPO	
Percentage of patient base from HMO	
Percentage of patient base from Medicaid	
Percentage of patient base with reduced fees plans	

Total Accounts Receivable amount (including pending insurance):_____

Average collection percentage over the last 12 months:_____

Practice Income Percentage Table: Should total 100%

Hygiene Production	
Operative	
Pedodontics	
Orthodontics	
Implants	
Removable Prosthetics	
Fixed Prosthetics	
Endodontics	
Periodontics	
Oral Surgery	
Cosmetic	
TMJ Treatment	
Soft Tissue Management	
Other	

Owner

Days Worked by Owner annually: _____ Average hours per day: _____

Average days worked per week: _____ Average days worked per year:_____

Busyness of Owner: ☐ Less than 1 week ☐ 1-2 Weeks ☐ 3-4 Weeks ☐ >4 Weeks

Average New Patients per Month (D0150):_____

Average Patients seen per day: _____DDS1 _____DDS2

_____RDH1 _____RDH2 _____RDH3

Practice Hours: M T W Th F

Total Doctor Hours worked per week: _____
Total Hygiene Hours worked per week:_____
Total Associate Hours worked per week:_____

Total Hygienist FTE: _____
Total Chairside FTE: _____
Total Front Desk FTE: _____
Total Number of Non-Dentist Employees:_____

*FTE is Full-time equivalent employee

Associate (if applicable)

Associate Name:_____

Written Covenant-Not-to-Compete Contract: ☐ Yes, (attach Copy) ☐ No

If Yes: _____ Years _____Mileage

Days Worked by Associate annually:_____ Average hours per day: _____

Average days worked per week: _____ Compensation rate: _____

Family Employment

Spouse Employed by the Practice: ☐ Yes ☐ No Salary $_____ FMV $_____

Describe Duties: _____

Children Employed by Practice: ☐ Yes ☐ No Salary $_____ FMV $_____

Describe Duties: _____

*FMV is the actual Fair Market Value of the family member as if paid to an unrelated party.

Facility Information

Facility: ☐ Owned ☐ Leased- Third Party
Current Rent Paid: $_____ per month

Actual Fair Market Value Rent, If Self-Owned: $_____

Square footage: _____Sq. Ft.

Equipped Ops: _____ Digital X-ray:_____
Plumbed Ops: _____ Digital Pan:_____
Total Ops: _____ Practice Management Software:_____

On a daily basis how many ops are used by:

DDS:_____ RDH_____ Total_____

Year facility built: _____ Latest remodel done: _____ year

Amount spent during last remodel: $_____

Current Facility Debt: $_____ Years remaining to pay in full:_____yrs.

Is facility for sale?_____

Tax Value (land plus building): $_____

Estimated Fair Market Value of building: $_____

Debt on the Practice

List all current liabilities on the practice and practice real estate, if owned.

_____
_____
_____

Information Needed from Owner Doctor

Please supply the following information or documents to help further your matter:

Accounting Information:

1. ☐ Past 3 years P&Lôs, if available
2. ☐ Past 3 years of tax returns
3. ☐ List of perks and approximate value taken through the practice annually (CE, Retirement Plan, Medical Insurance, Laptop computer, TV, Automobile, Etc.)
4. ☐ Copies of year-to-date and most recent year bank statements

Practice Information:

1. ☐ Current fee schedule
2. ☐ 6 / 12 month ñwindowò of office production for all procedures (all providers) by ADA code (a consolidated report).
3. ☐ Procedure count by ADA code
4. ☐ Photographs of the office.

Legal Agreements (if applicable):

1. ☐ Current Employment Agreement with Associate
2. ☐ Other

Asset Information:

1. ☐ Appraisal of dental equipment portion by a dental supply house
2. ☐ List of non dental assets included in Sale (equipment, furniture, computers, by serial number if possible. This list will be collateral for a Buyerôs Loan at the bank (See sample).
3. ☐ List of assets excluded from sale (i.e. Personal diplomas and photos). For a straight sale it is suggested to remove or replace any special pictures, or furniture not included in the sale prior to a buyer touring the premises.

Facility Real Estate Information (if owned):

1. ☐ Copy of recent property tax bill on the facility real estate
2. ☐ MAI appraisal of the facility real estate, if applicable.
3. ☐ Current condo agreement (if condo association)
    a. ☐ Capital Account balance $_____
    b. ☐ Any capital expense anticipated (roof, parking lot, etc) $_____
    c. ☐ Average monthly condo dues $_____/ month

Facility Real Estate Information (if leased):

1. ☐ Current Facility Lease Agreement

Please return this data sheet and all documents to JPA Dental Transitions, 547 Highland Street, Mount Holly, NC 28120 or via fax (704)-822-3142.

EMPLOYEE CENSUS

Summary of employees (Please include any benefits)

Illustration:

Name	W2-Wages*	CE	Medical Insurance	Uniforms	Retirement Match	Position	Working Hours Per Day	Total Compensation
Jane Smith	$24,300	$225	$3,360	$100	$N/A	25	8	$28,685
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$
	$	$	$	$	$			$

* Includes bonuses, paid vacation, sick leave, and holidays.
**All information should be on a yearly basis.