



GROWTH ASSESSMENT

DATE: _____

Name (include degree) _____

Corporate Name (if applicable) _____

Office Address _____

(City) (State) (Zip code)

Main Phone # _____ Back Line # _____ Fax Line # _____

Home Address _____

(City) (State) (Zip code)

Home Phone # _____ Cell # _____ E-Mail: _____

Type of Dentist: General Specialist (Specialty) _____

Sole Proprietorship Partnership; if yes what %? _____ Corporation Shared Space Other _____

FACILITY:

* Location: High Rise Strip Center Stand Alone Other _____

* Lease Own Situation * # of Treatment Rooms? Total _____ Doctor _____ Hygiene _____

TECHNOLOGY:

* Dental Software: No Yes; Type _____ How long have you used this software? _____

* Work Stations in Front Office? No Yes; how many? _____ Work Stations in ops? No Yes; how many? _____

RECALL:

* # of hygiene days/wk: _____ Days/mo: _____ Total # of patients seen in last 12 mos. _____

* 1st available appointment on hygiene schedule? _____

* Pre-appointing 6 mos. in advance? No Yes % Pre-appointed _____

SCHEDULING:

* Appointment scheduling is: Manual Computerized 10 minutes 15 minutes increments

* 1st available appointment on doctor's schedule? _____ weeks.

PRACTICE NUMBERS:

* Production Average per Month (last 6 mos.) _____

* Collections Average per Month (last 6 mos.) _____

* Total A/R=\$ _____ Over 90 days A/R? \$ _____

* New Patients per Month (average for last 6 mos.) _____

INSURANCE/PLANS:

* PPO's: No Yes; List _____ ; % _____

* DMO's No Yes; List _____ ; % _____

* Medicaid No Yes; List _____ ; % _____

TEAM/STAFF MEMBERS:

Name

Position

Years Employed in Your Practice

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

* Is your staff motivated and enthusiastic? No Yes

Concerns: _____

* Is there an associate in the practice? No Yes; how long? _____

* Associate will be: Employee Partner Other: _____

MOTIVATION:

* Bonus/Profit Pay System? No Yes; explain _____

* Trips: _____

* CE: _____

* Other incentives: _____

CASE ACCEPTANCE:

* Selling is done mainly by: Doctor Team Staff Member _____

* Are intraoral cameras used in case acceptance? No Yes; Frequency: _____

* Are digital photographs used in case acceptance? No Yes; Frequency: _____

PLEASE LIST ANY PREVIOUS CONSULTANTS/COACHES YOU HAVE WORKED WITH:

Name

Year

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE INCLUDE ANY ADDITIONAL INFORMATION THAT IS SPECIAL OR UNUSUAL TO YOUR PRACTICE THAT IS IMPORTANT FOR ME TO KNOW:

