

# SMILE, INC.

Coaching/Consulting/Marketing/Management  
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## 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. \_\_\_\_\_

\* 1<sup>st</sup> 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

\* 1<sup>st</sup> 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:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_