GROWTH ASSESSMENT
DATE: _______________

Name (include degree) ____

Corporate Name (if applicable) ____

Office Address ____

____

____

Main Phone # _____________ Back Line # ___________ Fax Line # ____________

Home Address ____

____
(City) (State)

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 using 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: ________________________.
* How far out is hygiene booked? ______________________________________.
* Preappointing 6 mos. in advance? No Yes % preappointed______________.

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:

* PPOs: No Yes; List ____; %________________________________
* DMOs No Yes, List ____; % _______________________________
* Medicaid No Yes; List ____; % _______________________________

TEAM: Name **Position** **Years Employed in Your Practice**

1 ____
2 ____
3 ____
4 ____
5 ____
6 ____
7 ____
8 ____
9 ____
10 ____
11 ____
12 ____
13 ____

* Is 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

What Year

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Any other information that is special or unusual to your practice that is important for me to know: