## Dental Practice Evaluation

**Please fax completed form to 727-674-1985**


**727-447-4756**

Best phone number to contact you to review your practice evaluation _____

Name _____

Practice Name _____

Address _____

Email Address _____

Office Phone Number _____

Number of Dentists in practice – General _____; Specialist _____

If specialist(s), please enter type of specialist(s)_____

Years in Practice _____

Total Gross Production Last Year

Monthly Production Goal _____

Total Collections Last Year

Monthly Collection Goal _____

Total Hygiene Production Last Year_____

Monthly Hygiene Goal _____

Number of Hygiene Days per Month _____

Total Accounts Receivable _____

Number of Team Members _____

Hygienists _____

Assistants _____

Administrative _____

Other _____

Number of Active Patients _____

Average Number of New Patients Monthly _____

Annual Marketing Budget _____

Average of Fee of Cases Presented _____

Average Percentage of Case Acceptance _____

Percentage of Patients with Dental Insurance – PPO _____; HMO_____; Medicaid _____

Number of Insurance Plans Accepted _____

Areas of concern _____

_____