DENTAL TRANSITIONS™

VALUATIONS | SALES | CONSULTING

PRACTICE VALUATION APPLICATION

ADS South, LLC
120 Istoria Drive
St. Augustine, FL 32095

770-664-1982
Fax: 678-965-1812
info@adssouth.com
www.adssouth.com

All ADS companies are independently owned and operated

Owner Personal Information - Please fill in completely and legibly

First Name ________________________ Middle Name ____________________ Last Name ________________________________

Degree DDS _____ DMD _____ Other _______ Date of Birth _________________ Spouse's Name ________________________

Practice Trade Name ____

GP or Specialty _____________________________ If incorporated, are you a "C" or an "S" Corporation? C ______ S _______

Corporation Suffix: PC _______ PA ________ APDC ________ LLC ________ LLP _______ Other _______________________

Name of President / Manager ____________________________________ Secretary _______________________________________

Name any other officers and all shareholders by percent interest ____

____

Reason for Appraisal ____ Date of Preparation ____________________

What is your website address? ____

Practice Street Address ____

City ________________________________County/Parish________________________________ State __________ Zip _________

Practice Phone Number ______________________ Fax Number _____________________ May we fax to this number? ________

E-mail Address ____ Can we send private e-mail to you? ___________

Website ____

Cell Phone Number _____________________________ Home Phone Number ___________________________

Home Street Address ____

City ____ State _____________________ Zip ______________

Accountant ____

Phone ______________________Fax________________ E-Mail ____

Attorney Name ____

Phone ______________________Fax________________ E-Mail ____

Leasing Agent Name ____

Phone ______________________Fax________________ E-Mail ____

How did you hear about ADS South, LLC? ____

<u>List of Items Required</u>

________ Last three years **Schedule C** from personal tax return **<u>with Statement of Other Expenses</u>**, ***<u>or</u>***

________ Last three years of the **<u>complete</u> Schedule 1120 or 1120S.**

________ Latest Year-to-date profit and loss statement for the current year.

________ Latest year's W-2 forms for employees with <u>employee's position written on each W-2.</u>

________ Aged Accounts Receivable Report (provide only the last one page summary)

________ Production by Provider report for last year and current year to date

________ Production by Category report for last year and current year to date

________ Production and Collection Summary Report

________ Report of patients by age

________ Report of patients by zip code or town

________ **Copy of contracts with any associates, partners, or employees**

________ A copy of your office lease.

________ A copy of any equipment appraisal report

________ Copies of any equipment leases and list of any leased equipment

________ Copy of your current fee schedule and fee schedule for any plans

________ List of loans against practice and payoff balances

________ Photographs of all rooms and exterior of office. (jpeg or pdf form)

________ A diagram of the office layout -- may be hand drawn.

________ Complete list of all major items to be included in the sale and date of acquisition of major items. (Use list on last pages)

________ List trade names and addresses of any other practices that you own and any shared employee positions

________ Appraisal fee of $2,950 for General Practice or $3,500 for specialty practices ($1,000 if executed Sales Consulting Agreement is sent with appraisal information). Call for fees for appraisals involving divorce valuations or testimony.

________ Your urgency in selling practice. ("10" represents selling in 30 days. "1" represents selling in 2 years.)

Personal Data

Dental School Alma Mater ____ Year Graduated _________________

Year Beginning Practice in City ______________________ Year Beginning Practice in Current Location ________________

Right or Left Handed ______________________________ Purchase or Scratch Start ________________________

From whom was practice purchased____ What Year ________________

Gross Income of practice when purchased $__________________ Purchase price of practice $___________________

Professional Organizations ____

Post Graduate Degree ___________________ Alma Mater____

Date Completed ________________________ Specialty or Designations _______________________________________

Board Qualified? _________________ Board Certified __________________ States Licensed: _________________________

Do you have an associate? _________________________ Do you have a partner? ___________________________

Do you share space? ____________________________ Is there an assignable written agreement? _________________

Is there a buy-out agreement? ______________________ Is there an assignable restrictive covenant? ________________

What are the terms of the covenant ____

What are the terms of the buy-out agreement ____

Has an associate or partner left your practice in the last two years? _________ When?_________________________________

Office Data

Office Sq. Footage ________________________________ Expandable Footage ________________________________

Current Monthly Rental Amount $_____________________ Is Office Handicapped Accessible? _____________________

Number of Parking Spaces _________________________ Proximity of Parking _________________________________

Total Number of Equipped Operatories ___________ Number of Plumbed But Unequipped Operatories __________

Number of Operatories used primarily by dentists ________ Number of Operatories used primarily by hygienists ________

Number of Unplumbed and Empty Operatories __________ Do you or your entity own your building? _________________

Do you want to sell the building? ________ Legal Name of Owner ____

Was building appraised? _________ When? ________________ Appraised Price $____________________

If not appraised, estimated price $______________________ If Not for Sale, Monthly Rental Amount $ _______________

Annual Property Taxes $______________________________ Annual Property Insurance $________________________

If you do not own your office, what is the Date of Lease _________________ Date Lease Ends ___________________

Describe any renewal options ____Option to Purchase?_________________

Post-Sale Information

Plans after the sale of your Practice ____

Days/Week Currently Worked: _________ **Enter number of days/week you would like to work for the buyer after the sale**

Desired Work Days/Week 1st Year _______ Desired Work Days/Week 2nd Year _______ Desired Work Days/Week 3rd Year _______

Desired Work Days/Week 4th Year _______ Desired Work Days/Week 5th Year _______ Desired Work Days/Week 6th Year _______

Practice Data

Has your practice been appraised before? __________ When? _____________ By Whom? ________________________

Previous Appraisal Price $________________ Have you previously tried to sell your practice? ____________ When? _________

Did you use a broker? _________ Who? ____________________________ Is your practice currently listed with another broker? _______

Who: ____________________ Have you used a management consultant in the past five years? _____ Who? ____________________

Results ____

Describe any internal marketing ____

____

Describe any external marketing ____

____

Has your practice gross changed significantly? ___________ Why: ____

____

Do you provide Nitrous Oxide? _______ Conscious Sedation or DOCS? _______ IV Sedation? _________ Mercury free? __________

Active patients (how many different patients treated in last 18 months) _______________ How many new patients per month ___________

Average number of patients treated per day by dentist __________________________by hygienist __________________________

How far ahead is owner scheduled? _______________________________ Hygienist? ________________________

% Practice Income from Cash _________% % of Patients Paying Cash __________%

% Practice Income from full fee Insurance __________% % of Patients with full fee Insurance __________%

% Practice Income from reduced fee plans __________% % of Patients with reduced fee plans __________%

% Practice Income from Capitation __________% % of Patients with Capitation __________%

% Practice Income from Medicaid __________% % of Patients with Medicaid __________%

Scheduling Data

Monday __________________ Tuesday _________________ Wednesday _________________

Thursday _________________ Friday _________________ Saturday _________________

Owner Hours Worked/Week _________________ Associate Hours Worked/Week __________________

Hygiene Hours Worked/Week _________________ Dentist Patient Visits Per Year _________________

Hygiene Patient Visits Per Year __________________ Number of Days Worked Per Year _________________

Number of Weeks Worked Per Year _______________ What is Your Collection Percentage? __________________

Actual Accounts Receivable Balance $_________________ What is the Patient Credit Balance? $_________________

Accounts Receivable: Current $___________ 30 days $__________ 60 days $__________ 90 days$_________ >90 days $___________

What Type Recall System? _________________________________ What Type Practice Management Software? ___________________

Production by Service

Hygiene ________% Operative ________% Pedodontics ________% Orthodontics _______% Implants _______%

Removable Prosthetics ________% Fixed Prosthetics ________% Endodontics ________% Periodontics __________%

Oral Surgery ________% Cosmetic ________% TMJ Treatment ________% Soft Tissue Management ________% Other ________%

TOTAL (should be 100%) __________% What is referred out? ____

Is any of your reported income from any other source than patient treatment from this practice?_______ If so, how much for each year?

$___________________ in 201___ $___________________ in 201___ $___________________ in 201___

What is the source of the other income? ____

Fee Schedule

Adult Prophy 01110 $______________

Two Surface Anterior Composite 02331 $______________

Core Build-Up Including Pins 02950 $______________

Crown - Gold/Porcelain 02750 $______________

Anterior Root Canal 03310 $______________

Panoramic X-Ray 00330 $_______________

Two Surface Posterior Composite 02386 $______________

Crown – Porcelain/Ceramic 06740 $______________

Labial Porcelain Veneer 02962 $______________

Bicuspid Root Canal 03320 $______________

Demographic Data

What is the approximate population of your city or town? ____________________ Of your drawing area? _______________________

Major employers in the area ____

____

Describe any major economic changes in your drawing area ____

____

Staff Data

Position	Month/Year Hired	Expected to stay?	***Annual*** Value of Benefits	***Annual*** Salary
Receptionist	______________	______________	$____________________	$__________________
Office Manager	______________	______________	$____________________	$__________________
Insurance	______________	______________	$____________________	$__________________
Other Front Desk	______________	______________	$____________________	$__________________
Bookkeeper	______________	______________	$____________________	$__________________
Assistant	______________	______________	$____________________	$__________________
Assistant	______________	______________	$____________________	$__________________
Assistant	______________	______________	$____________________	$__________________
Assistant	______________	______________	$____________________	$__________________
Assistant	______________	______________	$____________________	$__________________
Hygienist	______________	______________	$____________________	$_________________or _______%
Hygienist	______________	______________	$____________________	$_________________or _______%
Hygienist	______________	______________	$____________________	$_________________or _______%
Hygienist	______________	______________	$____________________	$_________________or _______%
Lab Technician	______________	______________	$____________________	$__________________
Lab Technician	______________	______________	$____________________	$__________________
Associate	______________	______________	$____________________	$_________________or _______%
Associate	______________	______________	$____________________	$_________________or _______%
Associate	______________	______________	$____________________	$_________________or _______%
Other ___________	______________	______________	$____________________	$______________________
Other ___________	______________	______________	$____________________	$______________________

What Benefits do you provide for the staff ?____

Cost of Benefits provided for each employee: ____

____

Do You Hire Any Unpaid Family? ___________ What position do they hold and what is the estimated fair market value of their job? ___________

____

Are there any family or other employees who are paid more/less than the normal salary for their position? _________________________________

Which positions and amount of over/under compensation for each? ____

____

Collection Centers

	Current Year to Date	Last Year	Two Years Ago
Year	1/1/201___ to _____/_____/201___	201__	201___
Gross Collections	$_________________	$__________________	$_______________
Owner	$ _________________	$__________________	$_______________
Hygienists	$_________________	$__________________	$_______________
Associate	$_________________	$__________________	$_______________
Associate	$__________________	$__________________	$_______________
Associate	$__________________	$__________________	$_______________

How is associate compensated? Amount? $___________________per year or __________________% of collections or production

How is hygienist compensated? Amount? $___________________per year or __________________% of collections or production

Practice Conformity Data

Does practice meet OSHA standards? _________ If not, why not? ____

____

Does practice conform with HIPAA requirements? ___________ Why not? ____

____

Do you forgive any insurance copayments? _____________ Explain and how much _______________________________________

____

____

Have you received any disciplinary actions in the past seven years? ____________ Explain_____________________________________

____

____

Have you had any practice-related lawsuits filed against you in the past ten years? _____________________________

Explain ____

____

____

Are there any health problems which would affect your practice of dentistry? ____________Explain_________________

____

____

Describe your practice, staff, patients, community and practice philosophy ____________________________________

____

____

____

____

____

____

____

____

____

Describe anything that would be considered a negative about your practice ____________________________________

____

____

____

____

____

____

____

____

____

Insurance Explanation

Total expense for Insurance $_______________________ How much of total is for owner health insurance? $_________________________

How much of total is for staff health insurance? $_________________ How much of total is for owner life insurance? $_____________________

How much of insurance is for owner personal benefits, i.e. disability? $_____________________

How much of total is for malpractice? $_______________________ How much of total is for building insurance? $_______________________

Taxes and Licenses Explanation

Total expense for taxes $_______________________ How much of total is for payroll taxes? $_________________________

How much of total is for staff payroll tax? $_________________ How much of total is for owner payroll tax? $_____________________

How much of total is for ad valorem / property taxes? $_________________ How much of total is for real estate taxes? $____________________

Pension Explanation

Total expense for pension plan $_______________________ How much of total is for staff? $_________________________

How much of total is for owner? $_______________________

Benefits Explanation

Total expense for employee benefits $_______________________ How much of total is for staff? $_________________________

How much of total is for owner? $_____________________

Reduced Fee Plans

Plan	% of pts. on plan	% of your fee paid by plan	Plan	% of pts. on plan	% of your fee paid by plan
	%	%			%
	%	%			%
	%	%			%
	%	%			%
	%	%			%
	%	%			%
	%	%			%
	%	%			%
	%	%			%

Specialty Practice Supplement for Orthodontic Practices

Total number of patients in treatment: Adult________ Child__________ Complete banding treatment patients: Adult ________Child_________

Partial banding treatment patients: Adult ________Child __________ Number of patients in partial treatment: Adult ________ Child ________

Patients in retention: Adult ___________Child ________________ Patients in TMJ treatment _________________________

Current contracts balance _______________ Accounts receivable balance (money past due) $__________________

Number of patients in treatment no longer paying fees __________ Attach a detailed list of patients and stage of treatment for each

New starts this year as of Jan. 1, 201____ ______________ New starts in last twelve (12) months ________________

Cost of average full treatment: Child $__________________ Adult $_____________

Average down payment for records $___________________ Banding $______________

Average fee per visit $_______________ Average fee per retention patient: Initial $_________ Periodic $_________

Average fee for partial treatment:: Adult $_____________ Child $______________

Average fee for TMJ treatment: $_______________

Do you use: Begg ______% Edgewise ________% Invisalign ________% Other - _______________ _______%

Describe technique, banding, etc. most commonly used: ____

____

What percent of your patients are from dentist referrals? _________%

Describe your referral base:____

____

____

Explain the best strengths and worst weaknesses of your practice::____

____

____

____

____

Specialty Practice Supplement for Oral Surgery Practices

What percent of practice is: Exodontia ______% Maxillofacial _______% TMJ _______% Cosmetic _______%

Trauma _______% Other ________% Describe ____

Describe typical anesthesia technique for in-office surgery: ____

____

At what hospitals do you have privileges? ____

Have you lost privileges at any hospital? ________ Which ones? ____

____

What percent of your patients are from dentist referrals? _________%

Describe your referral sources (number, ages, etc.) ____

____

Explain the best strengths and worst weaknesses of your practice ____

Specialty Practice Supplement for Periodontal Practices

What percent of practice income is: Implants ______% Surgical _______% Non-Surgical _______% Recall _______%

Other ________% Describe ____

Describe anesthesia techniques used: ____

____

What percent of your patients are from dentist referrals? _________%

Do you use a laser? ________ What brand? _______________ Do you have a cone beam X-Ray? Brand? ______________________

Describe implant treatment – brands, etc. ____

____

Describe your referral base: ____

Explain the best strengths and worst weaknesses of your practice

____

____

Equipment List

Under Acquired, enter approximate date of purchase

Under Description, enter Make and Model

Reception

Quantity Acquired Description

____ ________ ____________________ Waiting Room Chairs

____ ________ ____________________ Waiting Room Tables

____ ________ ____________________ Waiting Room Lamps

____ ________ ____________________ Pictures/Decorations

____ ________ ____________________ ______________

____ ________ ____________________ ______________

____ ________ ____________________ ______________

Business Office

Quantity Acquired Description

____ ________ ____________________ Business Office Desk

____ ________ ____________________ Business Office Chair

____ ________ ____________________ Copy Machine

____ ________ ____________________ File Cabinets

____ ________ ____________________ Typewriter

____ ________ ____________________ Computer

____ ________ ____________________ Printer

____ ________ ____________________ Software

____ ________ ____________________ _____________

____ ________ ___________________ _____________

____ ________ ___________________ _____________

____ ________ ___________________ _____________

____ ________ ___________________ _____________

Private Office

Quantity Acquired Description

____ ________ ________________________ Desk

____ ________ ________________________ Chair

____ ________ ________________________ Bookcase

____ ________ ________________________ ______________

____ ________ ________________________ ______________

Lounge

Quantity Acquired Description

____ ________ ________________________ Refrigerator

____ ________ ________________________ Table & Chairs

____ ________ ________________________ Microwave

____ ________ ________________________ _____________

____ ________ ________________________ _____________

____ ________ ________________________ _____________

Mechanical

Quantity Acquired Description

____ ________ ________________________ Compressor

____ ________ ________________________ Vacuum Pump

____ ________ ________________________ Air Dryer

____ ________ ________________________ ______________

____ ________ ________________________ _______________

X-Ray Equipment

Quantity Acquired Description

____ ________ ______________________ Panorex X-Ray

____ ________ ______________________ Cone Beam X-Ray

____ ________ ______________________ Film Processor

____ ________ ______________________ Developing Tank

____ ________ ______________________ _____________

____ ________ ______________________ _____________

Are X-Ray units Digital? _____________

Tanks

Quantity Acquired Description

____ ________ ______________________ Nitrous System

____ ________ ______________________ Tank Valves

____ ________ ______________________ Air Dryer

____ ________ ______________________ _____________

____ ________ ______________________ _____________

____ ________ ______________________ _____________

Lab

Quantity Acquired Description

____ ________ ______________________ Model Trimmer

____ ________ ______________________ Lathe

____ ________ ______________________ Furnace

____ ________ ______________________ Splash Hood / Shield

____ ________ ______________________ Vibrator

____ ________ ______________________ Casting Machine

____ ________ ______________________ Suck Down Unit

____ ________ ______________________ Articulators

____ ________ ______________________ Surveyor

____ ________ ______________________ Plaster Bins

Lab cont'd.

Quantity Acquired Description

____ ________ ______________________ Vacuum Mixer

____ ________ ______________________ Lab Handpieces

____ ________ ______________________ _____________

____ ________ ______________________ _____________

Sterilization

Quantity Acquired Description

____ ________ ______________________ Autoclave

____ ________ ______________________ Ultrasonic Cleaner

____ ________ ______________________ _____________

____ ________ ______________________ _____________

____ ________ ______________________ _____________

Hygiene #1

Quantity Acquired Description

____ ________ ______________________ Patient Chair

____ ________ ______________________ Dental Units

____ ________ ______________________ Doctor's Stool

____ ________ ______________________ Assistant's Stool

____ ________ ______________________ Light

____ ________ ______________________ Mobile Carts

____ ________ ______________________ Prophy Jet

____ ________ ______________________ Cavitron

____ ________ ______________________ High Speed HP

____ ________ ______________________ Low Speed HP

____ ________ ______________________ Curing Light

____ ________ ______________________ X-Ray Units

____ ________ ______________________ Computer

Hygiene #2

Quantity Acquired Description

____ ________ ________________________ Patient Chair

____ ________ ________________________ Dental Units

____ ________ ________________________ Doctor's Stool

____ ________ ________________________ Assistant's Stool

____ ________ ________________________ Light

____ ________ ________________________ Mobile Carts

____ ________ ________________________ Prophy Jet

____ ________ ________________________ Cavitron

____ ________ ________________________ High Speed HP

____ ________ ________________________ Low Speed HP

____ ________ ________________________ Curing Light

____ ________ ________________________ X-Ray Units

____ ________ ________________________ Computer

____ ________ ________________________ ______________

____ ________ ________________________ ______________

Hygiene #3

Quantity Acquired Description

____ ________ ________________________ Patient Chair

____ ________ ________________________ Dental Units

____ ________ ________________________ Doctor's Stool

____ ________ ________________________ Assistant's Stool

____ ________ ________________________ Light

____ ________ ________________________ Mobile Carts

____ ________ ________________________ Prophy Jet

____ ________ ________________________ Cavitron

____ ________ ________________________ High Speed HP

____ ________ ________________________ Low Speed HP

____ ________ ________________________ Curing Light

Hygiene #3 cont'd.

Quantity Acquired Description

____ ________ ________________________ X-Ray Units

____ ________ ________________________ Computer

____ ________ ________________________ Nitrous Meter

____ ________ ________________________ ______________

____ ________ ________________________ ______________

Hygiene #4

Quantity Acquired Description

____ ________ ________________________ Patient Chair

____ ________ ________________________ Dental Units

____ ________ ________________________ Doctor's Stool

____ ________ ________________________ Assistant's Stool

____ ________ ________________________ Light

____ ________ ________________________ Mobile Carts

____ ________ ________________________ Prophy Jet

____ ________ ________________________ Cavitron

____ ________ ________________________ High Speed HP

____ ________ ________________________ Low Speed HP

____ ________ ________________________ Curing Light

____ ________ ________________________ X-Ray Units

____ ________ ________________________ Computer

____ ________ ________________________ ______________

____ ________ ________________________ ______________

Operatory #1

Quantity Acquired Description

____ ________ ________________________ Patient Chair

____ ________ ________________________ Dental Units

____ ________ ________________________ Doctor's Stool

Operatory #1 cont'd.

Quantity Acquired Description

Quantity	Acquired	Description	
____	________	______________________	Assistant's Stool
____	________	______________________	Lights
____	________	______________________	Mobile Carts
____	________	______________________	Prophy Jet
____	________	______________________	HS HP's
____	________	______________________	SS HP's
____	________	______________________	Electric HP's
____	________	______________________	Curing Light
____	________	______________________	X-Ray Units
____	________	______________________	Computer
____	________	______________________	Nitrous Meter
____	________	______________________	Amalgamator
____	________	______________________	__________
____	________	______________________	__________
____	________	______________________	__________

Operatory #2

Quantity Acquired Description

Quantity	Acquired	Description	
____	________	______________________	Patient Chair
____	________	______________________	Dental Units
____	________	______________________	Doctor's Stool
____	________	______________________	Assistant's Stool
____	________	______________________	Lights
____	________	______________________	Mobile Carts
____	________	______________________	Prophy Jet
____	________	______________________	HS HP's
____	________	______________________	SS HP's
____	________	______________________	Electric HP's
____	________	______________________	Curing Light

Operatory #2 cont'd.

Quantity Acquired Description

Quantity	Acquired	Description	
____	________	______________________	X-Ray Units
____	________	______________________	Computer
____	________	______________________	Nitrous Meter
____	________	______________________	Amalgamator
____	________	______________________	__________
____	________	______________________	__________
____	________	______________________	__________

Operatory #3

Quantity Acquired Description

Quantity	Acquired	Description	
____	________	______________________	Patient Chair
____	________	______________________	Dental Units
____	________	______________________	Doctor's Stool
____	________	______________________	Assistant's Stool
____	________	______________________	Lights
____	________	______________________	Mobile Carts
____	________	______________________	Prophy Jet
____	________	______________________	HS HP's
____	________	______________________	SS HP's
____	________	______________________	Electric HP's
____	________	______________________	Curing Light
____	________	______________________	X-Ray Units
____	________	______________________	Computer
____	________	______________________	Nitrous Meter
____	________	______________________	Amalgamator
____	________	______________________	__________
____	________	______________________	__________
____	________	______________________	__________
____	________	______________________	__________

Operatory #4

Quantity Acquired   Description

____ ________ __________________________ Patient Chair

____ ________ __________________________ Dental Units

____ ________ __________________________ Doctor’s Stool

____ ________ __________________________ Assistant’s Stool

____ ________ __________________________ Lights

____ ________ __________________________ Mobile Carts

____ ________ __________________________ Prophy Jet

____ ________ __________________________ HS HP’s

____ ________ __________________________ SS HP’s

____ ________ __________________________ Electric HP’s

____ ________ __________________________ Curing Light

____ ________ __________________________ X-Ray Units

____ ________ __________________________ Computer

____ ________ __________________________ Nitrous Meter

____ ________ __________________________ Amalgamator

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

Operatory #5

Quantity Acquired   Description

____ ________ __________________________ Patient Chair

____ ________ __________________________ Dental Units

____ ________ __________________________ Doctor’s Stool

____ ________ __________________________ Assistant’s Stool

____ ________ __________________________ Lights

____ ________ __________________________ Mobile Carts

____ ________ __________________________ Prophy Jet

Operatory #5 cont’d.

Quantity Acquired   Description

____ ________ __________________________ HS HP’s

____ ________ __________________________ SS HP’s

____ ________ __________________________ Electric HP’s

____ ________ __________________________ Curing Light

____ ________ __________________________ X-Ray Units

____ ________ __________________________ Computer

____ ________ __________________________ Nitrous Meter

____ ________ __________________________ Amalgamator

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

Operatory #6

Quantity Acquired   Description

____ ________ __________________________ Patient Chair

____ ________ __________________________ Dental Units

____ ________ __________________________ Doctor’s Stool

____ ________ __________________________ Assistant’s Stool

____ ________ __________________________ Lights

____ ________ __________________________ Mobile Carts

____ ________ __________________________ Prophy Jet

____ ________ __________________________ HS HP’s

____ ________ __________________________ SS HP’s

____ ________ __________________________ Electric HP’s

____ ________ __________________________ Curing Light

____ ________ __________________________ X-Ray Units

____ ________ __________________________ Computer

____ ________ __________________________ Nitrous Meter

Operatory #6 cont'd.

Quantity Acquired Description

____ ________ __________________________ Amalgamator

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

Operatory #7

Quantity Acquired Description

____ ________ __________________________ Patient Chair

____ ________ __________________________ Dental Units

____ ________ __________________________ Doctor's Stool

____ ________ __________________________ Assistant's Stool

____ ________ __________________________ Lights

____ ________ __________________________ Mobile Carts

____ ________ __________________________ Prophy Jet

____ ________ __________________________ HS HP's

____ ________ __________________________ SS HP's

____ ________ __________________________ Electric HP's

____ ________ __________________________ Curing Light

____ ________ __________________________ X-Ray Units

____ ________ __________________________ Computer

____ ________ __________________________ Nitrous Meter

____ ________ __________________________ Amalgamator

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

Operatory #8

Quantity Acquired Description

____ ________ __________________________ Patient Chair

____ ________ __________________________ Dental Units

____ ________ __________________________ Doctor's Stool

____ ________ __________________________ Assistant's Stool

____ ________ __________________________ Lights

____ ________ __________________________ Mobile Carts

____ ________ __________________________ Prophy Jet

____ ________ __________________________ HS HP's

____ ________ __________________________ SS HP's

____ ________ __________________________ Electric HP's

____ ________ __________________________ Curing Light

____ ________ __________________________ X-Ray Units

____ ________ __________________________ Computer

____ ________ __________________________ Nitrous Meter

____ ________ __________________________ Amalgamator

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

____ ________ __________________________ ____________

Are computers networked? __________________________

Is all equipment in working condition? ________________________

If not, describe exceptions: ____________________________________

____

____

____

____

List any other equipment to be included

Quantity Acquired Description

____ _______ _________________________ Cerec/CAD/CAM

____ _______ _________________________ Zoom

____ _______ _________________________ Laser

____ _______ _________________________ Laser

____ _______ _________________________ Intraoral Camera

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

____ _______ ______________________ _____________

Other

Is any equipment shared with another owner? ________________

Please list: ____

____

____

Is all equipment in working condition? _______________________

If not, describe exceptions: __________________________________

____

____

____

____

List any items **not** to be included:

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

____ ______________________________________

Will you leave at least a one month inventory of supplies? _________

Describe any defects in your practice or building that could affect its value or performance ____________________________________

____

____

____

____

____

____

Do you warrant your treatment? ___________

Describe warranty ____

____

I attest that all of the information that I have provided to ADS South, LLC is true to the best of my knowledge and that there are no omissions of any information that would materially alter the value, desirability, or performance of my practice.

Signature:____

Print Name: ____

Date: ____

Office Layout

Please provide diagram of office layout (may be hand drawn).