SUNRISE DENTAL SOLUTIONS

make more, keep more, enjoy more

Tell Us About Your Practice

Dr. _____

Address _____

City _____ **State** _____ **Zip**_____

Office Phone Number _____ **Doctor Cell Phone Number** _____

Email Address _____

List all Providers (Dentists, Hygienists) in your practice (if there are multiple locations, please fill out this form for each location):

	Name	Avg. # of days worked/month	Avg. Daily Production
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Rate the following practice attributes using a scale of 1 – 10:

1 = this area is a severe challenge for the practice **10** = the practice is rarely equaled in this area

Facility _____

Scheduling Efficiently to Reach Goal_____

Productive Treatment Mix_____

Appropriate Fees for Quality of Care_____

Working enough days to Reach Goals_____

Clinical Speed (efficiency in the clinic)_____

Have enough High-Quality Team Members _____

Cash Flow _____

Case Acceptance _____

Diagnosis and Treatment Planning _____

Have Enough New Patients _____

Have Enough High-Quality New Patients _____

Are Cancellations/Failures an issue in your Practice? Doctor _____ Hygiene _____

What % of Dentistry Produced is Collected? _____

Does the Practice Participate in an PPO's, HMOs? _____

What % of Collections are Collected at the Time of Service or in Advance? _____

Are Financial Arrangements Signed before Treatment, an Implemented Policy? _____

What was the Average Monthly Production for the last 6 months? _____

What was the Average Monthly Collections for the last 6 months? _____

How Much Delinquent Accounts Receivables Fall into the Following Categories?

31 – 60 Days $ _____ 61-90 Days $ _____ Over 90 Days $ _____

# of Team Members: Hyg. _____ Asst. _____ Business Office _____ Other _____

# of Operatories: Doctor _____ Hyg. _____ Is there Room for More Operatories? _____

How many New Patients does the Practice Average per month? _____

What do you feel are your biggest Strengths as a Practice?

_____

_____

_____

What do you feel are your biggest Weaknesses as a Practice?

_____

_____

_____

What would you like to see happen in Your Practice over the next year?

_____

_____

_____

What's standing in the way of this happening?

_____

_____

_____

Confidentiality Statement: This form, and any files transmitted with it are considered confidential and intended solely for the use of Sunrise Dental Solutions in its assessment of the prospective client for services provided by Sunrise Dental Solutions.

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