



## General Information

Practice Owner/Seller \_\_\_\_\_

Practice Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_

Contact Phone # \_\_\_\_\_ Confidential?  Yes  No Fax # \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Broker's Name \_\_\_\_\_ Broker's Phone # \_\_\_\_\_  
 (\_\_\_\_\_) \_\_\_\_\_

Legal Counsel's Name \_\_\_\_\_ Legal Counsel's Phone # \_\_\_\_\_  
 (\_\_\_\_\_) \_\_\_\_\_

Accountant's Name \_\_\_\_\_ Accountant's Phone # \_\_\_\_\_  
 (\_\_\_\_\_) \_\_\_\_\_

## Collection Sources

Office Payment: \_\_\_\_\_% Insurance: \_\_\_\_\_%

Medicare: \_\_\_\_\_% HMO/Capitalization: \_\_\_\_\_%

PPO: \_\_\_\_\_% Medicaid: \_\_\_\_\_%

If Owner is a member of any HMO/PPO/Capitalization programs, will Buyer assume these contracts?  Yes  No

Are accounts receivable being sold separately from the practice purchase price?  Yes  No  
 If Yes, please attach up-to-date aging report.

## Practice Profile

Number of days a month Owner works in practice: \_\_\_\_\_

Number of treatment rooms: \_\_\_\_\_

Age of equipment: \_\_\_\_\_

Why is the practice being sold? \_\_\_\_\_

Marketing techniques currently used (check all that apply):

TV/Radio  Video Postcard  Yellow Pages  Direct Mail

Patient Referrals  Other (specify) \_\_\_\_\_

## Seller Background

Does Owner share space with another doctor?  Yes  No

Does Owner own any other practices?  Yes  No

If yes:

Location	Distance (in miles) from practice being sold
_____	_____

Which practice is the buyer purchasing?  Primary  Secondary

Will the Buyer and Owner consolidate practices?  Yes  No

If yes, where will merged practice be?

Location	Distance
_____	_____

Any existing liens on the practice, including equipment leases?  Yes  No

Is Owner involved in any litigation not covered by insurance?  Yes  No

If yes, explain on an attached page.

## Practice Overview

Practice has been at location for: \_\_\_\_\_ years

Owner has been at location for: \_\_\_\_\_ years

Owner has owned practice for: \_\_\_\_\_ years

Owner to remain after sale for: \_\_\_\_\_ months

Compensation for Owner after sale: \$ \_\_\_\_\_

Owner's projected post-sale production: \$ \_\_\_\_\_

Does Owner employ associate/independent contractor?  Yes  No

If yes:

Last year's associate(s) collections: \$ \_\_\_\_\_

Last year's associate(s) compensation: \$ \_\_\_\_\_

Is (are) the associate(s) under a non-compete?  Yes  No

Will the associate(s) stay on after sale?  Yes  No

Do you employ a hygienist, or other specialized assistant that generates revenue/income for the practice?  Yes  No

If Yes, please indicate last year's collections: \$ \_\_\_\_\_

## Patient Information

Average Number of New Patients Per Month: \_\_\_\_\_

Number of Active Patients seen in last 18 months: \_\_\_\_\_

## Practice Performance

Procedure	% of Production
Hygiene	_____ %
Endodontics	_____ %
Orthodontics	_____ %
Restorative	_____ %
Periodontics	_____ %
Oral Surgery	_____ %
Crown & Bridge	_____ %
Prosthodontics	_____ %
Other _____	_____ %
Other _____	_____ %
Other _____	_____ %
Other _____	_____ %
Other _____	_____ %

## Office Hours

Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_  
 Thursday \_\_\_\_\_ Friday \_\_\_\_\_ Saturday \_\_\_\_\_  
 Sunday \_\_\_\_\_

## Office Staff Information

Please complete the below table for all office staff:

Position	Days/Week	Salary	Remaining with Practice?
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Are there any family members employed at the practice?  Yes  No Will they be employed by the Buyer?  Yes  No

Are any family members who aren't employed at the practice being paid through the practice?  Yes  No

What are their wages? \_\_\_\_\_

Owner formed/organized/incorporated the legal entity that owns and is selling the practice in which state: \_\_\_\_\_

Owner personally resides in which state: \_\_\_\_\_

Please provide any additional information which will explain or enhance the data contained in this package on an attached page.

**I certify that the information provided to CapitalSource in connection with the sale or refinancing of my practice was provided by me and is accurate and complete. By signing this document I confirm this information to be accurate and authorize CapitalSource to use this information.**

\_\_\_\_\_  
Practice Owner

\_\_\_\_\_  
Date