



Seller Information

Name _____

Selling Office Address _____ City _____ State _____ Zip _____
 (_____) _____ (_____) _____
 Office Phone # _____ Office Fax # _____

Home Address _____ City _____ State _____ Zip _____
 (_____) _____ (_____) _____
 Home Phone # _____ Home Fax # _____

Legal Counsel's Name _____ (_____) _____ Legal Counsel's Phone # _____ Legal Counsel's E-Mail _____
 (_____) _____

Accountant's Name _____ (_____) _____ Accountant's Phone # _____ Accountant's E-mail _____

Referral Source (i.e. Broker)

Name _____ Firm _____
 (_____) _____ (_____) _____
 Office Phone # _____ Office Fax # _____ E-mail _____

Practice Information

Sq Ft of office space: _____

Room available for expansion: Yes No

Number of Lanes: _____

Number of Equipped Lanes: _____

Lab: Yes No

Reason for selling: _____

How long has seller been at location: _____

How long has current owner operated practice: _____

Property: Rent Own

Lease available: Yes No

Remaining term of lease: _____

Renewal option available? Yes No

Will buyer assume lease or write new lease? _____

Multi-tenant? Yes No

Is property for sale? Yes No

If yes, property value: \$ _____

If no, monthly rent: \$ _____

Please provide a brief description of location:

Landlord Name _____

Address _____

City _____ State _____ Zip _____

(_____) _____ (_____) _____
 Phone # _____ Fax # _____

E-mail _____

Current Personnel

Is staff aware of sale? Yes No

If not, when will the staff be informed? _____

Will staff remain with practice? Yes No Unknown

Practice-related litigation? Yes No

Associates: # _____ Lab Techs: # _____

Managers: # _____ Receptionists: # _____

Opticians: # _____ Other: # _____

Total _____

Practice Information (continued)

Office Hours

Monday _____ Tuesday _____ Wednesday _____
 Thursday _____ Friday _____ Saturday _____
 Sunday _____

Average Patient Age

<20 _____% 21--60 _____% >60 _____%

Percentage of OD/Optician Revenues

Exams _____% Eye Glasses _____% Contact Lens _____% Medical Eye Care _____% Other _____%

Percentage of Ophthalmic Revenues

LASIK/LASEK _____% Cataract _____% Glaucoma _____% Cosmetic _____% Oncology _____% Cornea _____%
 Retina _____% Other _____%

Within the last 18 months, what is the:

Approximate # of active patient records: _____ Average # of new patients per month: _____
 Average # of patients seen by doctor(s) per day: _____ Average # of patients seen by Optician(s) per day: _____

Marketing Techniques (check all that apply)

- TV/Radio Video Postcard Yellow pages Direct Mail Patient Referrals
 Other (specify) _____

Patient Financial Type Fee for service _____% VSP _____% Insurance _____% PPO (other) _____%

Reduced fee plan _____% Describe reduced fee plan: _____

Will seller remain with practice after sale? Yes No If yes, for how long: _____ What is the compensation: \$ _____/month

Additional skills buyer brings to practice: _____

Annual increase in revenues anticipated: \$ _____

Transition plan: _____

Any unusual characteristics of this practice? _____

Are 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: _____

I hereby certify that the information above is true and correct to the best of my knowledge.

Practice Owner

Date

