ADS® Practice Transitions Made Perfect™

PRACTICE VALUATION APPLICATION

ADS South, LLC
24 Cathedral Place Suite 600
St. Augustine, FL 32084

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info@adssouth.com
www.adssouth.com

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 a "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? _____

List of Items Required

_____ Last three years **Schedule C** from personal tax return **with Statement of Other Expenses**, ***or***

_____ Last three years of the **complete** **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 employee's position written on each W-2.

_____ Aged Accounts Receivable Report (provide only the 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.

_____ 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? _____

Collections 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 $_____

Panoramic X-Ray 00330 $_____

Two Surface Anterior Composite 02331 $_____

Two Surface Posterior Composite 02386 $_____

Core Build-Up Including Pins 02950 $_____

Crown – Porcelain/Ceramic 06740 $_____

Crown - Gold/Porcelain 02750 $_____

Labial Porcelain Veneer 02962 $_____

Anterior Root Canal 03310 $_____

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 Collections	Last Year Collections	Two Years Ago Collections
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	Percent of your standard fee	Plan	Percent of your standard fee
_____	_____%	_____	_____%
_____	_____%	_____	_____%
_____	_____%	_____	_____%
_____	_____%	_____	_____%
_____	_____%	_____	_____%
_____	_____%	_____	_____%
_____	_____%	_____	_____%
_____	_____%	_____	_____%
_____	_____%	_____	_____%
_____	_____%	_____	_____%

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

____ _____ _____ 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

____ _____ _____ 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

____ _____ _____ X-Ray Units
____ _____ _____ Computer
____ _____ _____ Nitrous Meter
____ _____ _____ Amalgamator
____ _____ _____ _____
____ _____ _____ _____
____ _____ _____ _____

Operatory #3

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).