Practice Evaluation

Please email completed form to: info@consultingaim.com

Best phone number to contact you to review your practice evaluation _____
Name _____
Practice Name_____
Address _____
Email Address _____
Office Phone Number_____

No. of Providers in practice_____ Type of Practice _____
If specialist(s), please enter type of specialist(s)_____
Years in Practice _____ Total Gross Production Last Year_____
Monthly Production Goal _____ Total Collections Last Year_____
Monthly Collection Goal _____ Total Production Last Year_____
Total Accounts Receivable_____

ONLY ANSWER CONTENTS IN BOX IF YOU ARE A DENTAL PRACTICE

Total Hygiene Production Last Year _____Monthly Hygiene Goal_____
No. of Hygiene Days/Month _____ No. Hygienists _____

No. of Team Members _____ Clinical Team Members _____ Administrative _____ Other _____
No. of Active Patients _____ Avg No. New Patients Monthly _____
Annual Marketing Budget _____ Avg Fee of Cases
Presented_____ Average Percentage of Case Acceptance _____%
Cost of Monthly Inventory_____ Total Cost of Monthly Payroll _____
Total Monthly Operating Cost _____

No. of Team Members _____ Clinical Team Members _____ Administrative _____ Other _____
No. of Active Patients _____ Avg No. New Patients Monthly _____
Annual Marketing Budget _____ Avg Fee of Cases presented _____
Average Percentage of Treatment Acceptance _____%

Percentage of Patients with Insurance – PPO _____; HMO_____; Medicaid _____
Number of Insurance Plans Accepted _____

Areas of concern

_____
_____
_____
_____
_____