



### **Practice Analysis Worksheet**

Thank you for considering Symphony Dental for your business. Following is a questionnaire that will assist us in our analysis process and getting to know you. Upon completion, please fax or mail this form to our Advisor Team for a Complimentary Telephone Consultation. *All information will be held in strict confidence.*

#### **1. Business Information:**

Company Name:

Address:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Web page URL: \_\_\_\_\_

#### **2. Contact Information:**

Primary Contact Name:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

#### **3. Describe your goals for your Practice:**

This Year:

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Next Year:

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Five Years from Now:

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Ten Years from Now:

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4. If **you knew you could not fail**, what changes would you make in your practice?

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**5. Please give us your financial performance background:**

Gross Annual Production:

2014 \_\_\_\_\_

2015 \_\_\_\_\_

2016 \_\_\_\_\_

2017 to date \_\_\_\_\_

Annual Collections (Total Dollars or Per Cent of Production)

2014 \_\_\_\_\_

2015 \_\_\_\_\_

2016 \_\_\_\_\_

2017 to date \_\_\_\_\_

**6. Tell Us About Your Team:**

	<b>How Many?</b>	<b>Full Time</b>	<b>Part Time</b>
Dental Assistants	_____	_____	_____
Hygienists	_____	_____	_____
Hygiene Assistants	_____	_____	_____
Administrative Staff	_____	_____	_____
Office Manager(s)	_____	_____	_____
Other: _____	_____	_____	_____

**7. Insurance Management**

Do you accept assignment of insurance benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you participate in PPO/DMO Plans? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you lower your fees to participate in any insurance/discount plans? Yes \_\_\_\_\_ No \_\_\_\_\_

**8. Please rate your Practice in the following areas:**

	<b>Poor</b>	<b>Satisfactory</b>	<b>Highly Effective</b>
Scheduling	_____	_____	_____
Collections	_____	_____	_____
Soft Tissue Management Program (STMP)	_____	_____	_____
Clinical Dr/Asst Operations	_____	_____	_____
Case Presentation	_____	_____	_____
Co-Diagnosis	_____	_____	_____
Technology Implementation	_____	_____	_____
Patient Retention	_____	_____	_____
New Patient Activity	_____	_____	_____
Marketing Activity	_____	_____	_____
Treatment Acceptance	_____	_____	_____
Cash Flow	_____	_____	_____
Insurance Management	_____	_____	_____
Personnel Management/ Motivation	_____	_____	_____
Team Communication	_____	_____	_____

**For any areas marked "poor" or "highly effective", please explain.**

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**9. List and describe the top 3 Challenges that you face in your practice today:**

(1)

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(2)

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(3)

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**Thank you for this opportunity to assist you with your goals. Upon receiving your completed questionnaire, our Client Advisor will contact you to schedule a 20-minute telephone consultation to learn more about your current situation.**

**Please let us know the preferred day/time to schedule your consultation:**

Day of Week \_\_\_\_\_

Time of Day \_\_\_\_\_

Phone Number to Call \_\_\_\_\_

**Who should we call to schedule?**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Please indicate if you DO NOT want us to call you at the office \_\_\_\_\_**

Please send this questionnaire:

Symphony Dental  
Attn: Deborah Druey  
P.O. Box 604  
Temple, Ga 30179-0604

Phone: (678) 563-6122  
Fax: (844) 749-4751

Email: [ddruey@symphonydental.com](mailto:ddruey@symphonydental.com)

**Thank you for taking time to complete this questionnaire.**

**Please do not hesitate to contact us if you have any questions or thoughts about your Practice Analysis.**