

PRACTICE VALUATION APPLICATION SELLER PRACTICE PROFILE

WATSON, BROWN & ASSOCIATES, INC.

Return to:

- Terry D. Watson, DDS and Frank J. Brown, JD, LL.M.(taxation)

Mailing Address:
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twatson@wb-associates.com and fbrown@wb-associates.com

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PRACTICE PROFILE

**Please print in BLACK INK and return completed forms with all additional information requested.
Incomplete responses and failure to provide all information requested delays starting Appraisal
All pages except 1 and 2 will be included in the Valuation Report.**

GENERAL INFORMATION

Check all that apply:

DEGREE:

D.M.D. Other(_____)
 D.D.S.

BUSINESS ORGANIZATION TYPE:

P.C. Inc. C Corp Sole Proprietor
 P.A. Other S Corp Partnership

Owner's Name: _____
First M.I. Last

Date of Birth: _____

Corporate or other Practice Name: _____

Corporate: President's Name: _____

Vice-President's Name: _____

Secretary's Name: _____

Office Address: _____ Suite #: _____

City: _____ County: _____ State: _____ Zip: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Website: _____

Your preferred location to direct our correspondence: Home Office Email Fax
 Other _____

Spouse's Name: _____
First M.I. Last

Office Phone: _____ Office Backline: _____

Office Fax: _____ [Secure: Y N] Pager: _____

Home Phone: _____ Cell Phone: _____

Home Fax: _____ [Secure: Y N] Secure Email: _____

May we send confidential communications to the above secure areas? Yes No

Purpose of the Appraisal: _____

Your urgency if selling the practice: _____ (Enter a number from 1 to 10. "10" represents selling in 30 days. "1" represents selling in 2 years.)

What are your plans after selling the practice? _____ Describe any health problem. _____

Which staff members are aware of this appraisal? _____

Do they know the purpose of the appraisal? Yes No

How did you hear about or who referred you to Watson, Brown & Associates, Inc.? _____

ADDITIONAL INFORMATION REQUESTED (Copies Only – Data not Returned.)

Please advise us immediately if more than one practice is reported on the tax returns or financial statements.

Enclosed (Please check-off items provided.)

- Last three years Tax Returns. (If sole proprietor provide Form 1040 Schedule C, include statement of “**other expenses**”, if corporation provide Form 1120 or 1120S with statement of “**other expenses**”, partnerships 1065
- Practice financial statements for the last three years. (include income statement & balance sheet)
- Practice interim (year to date) financial statements for the periods:(beginning of tax year through ___/___/___)
- Latest detailed Depreciation Schedule. (if not included with tax return)
- Previous year’s W-2 forms, identify job description for each employee. (e.g. chairside, hygienist, front office etc.)
- Current signed Office Lease with any extensions, if you do not own your office.
- Employment Contracts with associates, partners, and/or employees. (including covenants not to compete)
- Contracts. (telephone ads, telephone services, service and maintenance agreements, warranties, etc.)
- Equipment Leases. (postage machine, credit card processor, dental equipment, office equipment,. etc.)
- First page of monthly Bank Statements since the beginning of the current year.
- Accounts Receivable aging Report.
- Your current fee for service schedule and fee schedules for any reduced fee plans.
- Photographs of all rooms and exterior of office. (prefer 3x5 prints)
- Diagram of the office layout – may be hand drawn. (worksheet provided)
- Office Equipment Inventory List. (recommended to have equipment appraisal from dealer rep., if not available complete worksheet provided)
- List of items excluded from sale. (worksheet provided)
- Lien Holder(s) Note(s) – Loans secured by practice assets.
- Appraisal Fee of \$4,000 (only \$1,500 due with Profile if Seller Listing Agreement or Consulting Agreement is entered into with WB&A)

(All information requested must be supplied and completed before appraisal is started)

PROFESSIONAL ADVISORS

ACCOUNTING FIRM: _____

Your Accountant’s Name: _____

Office Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

LAW FIRM: _____

Your Attorney’s Name: _____

Office Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

CONSULTING FIRM: _____

Your Consultant’s Name: _____

Office Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

LANDLORD’S OR LEASING COMPANY’S NAME: _____

Your Leasing Agent’s Name: _____

Office Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ E-mail: _____

EDUCATION INFORMATION

	Institution	Degree	Date Completed
Undergraduate	_____	_____	_____
Dental School	_____	_____	_____
Graduate School/Residency	_____	_____	_____
Specialty Training	_____	_____	_____

Board Qualified: Yes No Board Certified: Yes No

What Professional Organizations do you belong to? ADA State Local(_____) Study Group(_____)

How many hours of Continuing Education have you completed in the last 24 months? _____ Hours

What courses? _____

PRACTICE HISTORY

Year began practice in present city: _____ Year began practice in present location: _____

	Former Owner	Current Status of Former Owner
Did you Purchase your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No When _____	_____	_____
Did you Start your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No When _____	_____	_____
Do you practice in Another Office? <input type="checkbox"/> Yes <input type="checkbox"/> No Where _____	_____	_____

If yes, is it within the subject practice drawing area? Yes No

YES	NO	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you incorporated?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your corporation own the equipment? Describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a partner? Name: _____ Start Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Do you have a contract with your partner?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Do you have a buy-out agreement with your partner?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Is there a restrictive covenant?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an associate? Name: _____ Start Date: _____ Compensation Formula: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Do you have a contract with your associate?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Do you have a buy-out agreement with your associate?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Is there a restrictive covenant?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a partner or associate leave within the last 3 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you share space with another dentist? If yes, please describe the arrangement and include a copy of the agreement. _____

FACILITY

Do you Own or Lease your office? OWN LEASE

Size of the office: _____ Sq. Ft. Expandable: _____ Sq. Ft.

Parking: Number of Spaces# _____ Proximity of Parking: Adjacent Parking Garage Free Charge(\$ _____)

Is the office Handicapped Accessible? Yes No

Number of Treatment Rooms: Doctor # _____ Hygiene # _____ Additional Rooms: Plumbed # _____ Not Plumbed # _____

Treatment Rooms set up for: Right-Handed Delivery _____ Left-Handed Delivery _____ Interchangeable _____

FOR LEASEES:

Date Lease Entered: _____ Date Lease Expires: _____

Options to Renew: Yes No Length of Option Term: _____ Yrs. Lease Rate for Option Renewal: \$ _____

Current Total Monthly Rent: \$ _____ When does Rent increase? ____/20__ What is New Monthly Rent: \$ _____

What is included in the Monthly Rent? Water Electrical Gas Janitorial Property Taxes
 Building Insurance Security Common Area Maintenance Parking

Other Services Paid for Separately (Not Included in Rent): Describe _____

Is the Lease Transferable pursuant to its terms? Yes No

FOR OWNERS OF OFFICE REAL ESTATE:

Do you wish to sell the Real Estate? Yes No Sale Price: \$ _____

Current Annual Real Estate Taxes: \$ _____

Current Annual Real Estate Insurance: \$ _____

Average Annual Real Estate Maintenance Costs: \$ _____

Are the above Real Estate Costs paid directly by: Practice Personally Company owned by Dentist

Is there a current Real Estate Appraisal? Yes No

Date of Appraisal: _____ Appraised Value: \$ _____

IF NOT SELLING REAL ESTATE:

Rental Term in years: _____ years Monthly Rental: \$ _____

What is included in the Monthly Rent? Water Electrical Gas Janitorial Property Taxes
 Building Insurance Security Common Area Maintenance Parking

Will you Lease with Option to Purchase? Yes No Describe: _____

Will you owner finance? Yes No Terms for Owner Financing: _____

PRACTICE INFORMATION

You currently work _____ days per week. Number of Vacation + Holidays + CE days / year? _____

You currently work _____ weeks per year.

How many days per week do you plan on working in the practice after the sale?

If merging with another practice, how many days per week do you plan on working in the practice after the merger?

Year 1 _____ days/week
Year 2 _____ days/week
Year 3 _____ days/week
Year 4 _____ days/week
Year 5 _____ days/week
Year 6 _____ days/week
Year 7 _____ days/week

Year 1 _____ days/week
Year 2 _____ days/week
Year 3 _____ days/week
Year 4 _____ days/week
Year 5 _____ days/week
Year 6 _____ days/week
Year 7 _____ days/week

What practice consultants have you used in the past 5 years? _____
When? _____

What were the results? _____

Describe any internal marketing used: _____

Describe any external marketing used: _____

Number of Patients on Active Hygiene Recall: _____

Number of Active Patients (Patients seen in last 18 months): _____

How did you calculate Patient count: ___ Computer Count ___ Actual Manual Count

Is Appointment Book kept on: ___ Computer ___ Manually.

Number of New Patients seen per month over the last year: ___Jan ___Feb ___Mar ___Apr ___May ___June
___July ___Aug ___Sept ___Oct ___Nov ___Dec

Average # New Patients per Month: _____ Average # of cancellations per Day: _____

Average # Patients seen per day - Dentist: _____ Average # Patients seen per day – Hygienist: _____

How far ahead are you booked? Dentist: ___weeks Hygienist: ___weeks Average # of Hygiene Days per week: _____

What percentage of practice income is from?

Fee For Service _____%(What % FFS is: Cash _____%, Credit Card _____%, Indemnity Ins. _____% Financed _____%)

HMO _____% PPO _____% Capitation _____% Medicaid _____% Other Reduced Fee Plans _____%

Monthly Payment from Capitation Plans: \$ _____ What PPO Plans _____

What PPO Plans cancelled & when? _____

The Office is staffed during these Hours:

M _____ T _____ W _____ Th _____ F _____ S _____

Patients are seen in the Office during these Hours:

M _____ T _____ W _____ Th _____ F _____ S _____

Doctor's Hours in the Office:

M _____ T _____ W _____ Th _____ F _____ S _____

Hygiene Hours in the Office:

M _____ T _____ W _____ Th _____ F _____ S _____

What is balance of Accounts Receivable? \$ _____ What is your Collection Ratio? _____

What type of Recall System is in use? _____

What type of Computer System and Software is in the office? _____

Is Software Assignable? ___ Yes ___ No

Is there a Fee for Assignment? ___ Yes ___ No How much is Transfer Fee: \$ _____

Provide Computer Print-out of Production by Procedure Report by Major Classifications (Procedures designated by ADA Code), otherwise estimate what percentage of your practice is:

Preventative/Hygiene/Diagnostic	_____%	Operative	_____%
Pedodontics	_____%	Orthodontics	_____%
Implants	_____%	Removable Pros.	_____%
Fixed Pros.	_____%	Endodontics	_____%
Periodontics	_____%	Oral Surgery	_____%
Cosmetic	_____%	TMJ Treatment	_____%
Soft Tissue Management	_____%	Other _____	_____%
		TOTAL	100%

What procedures do you referred out? _____

FEE SCHEDULE:

Adult Prophy **01110** \$ _____ Gold Inlay **02540** \$ _____ Two Surface Posterior Composite **02386** \$ _____

Two Surface Amalgam **02150** \$ _____ Core Build-Up Including Pins **02950** \$ _____

Gold/Porcelain Crown **02750** \$ _____ Anterior Canal Root Canal **03310** \$ _____

Bicuspid Root Canal **03320** \$ _____ Labial Porcelain Veneer **02962** \$ _____

When was the last fee increase? _____ What percentage was the last fee increase? _____%

Are the fees low, average, or high compared to other practices in your area? ___ Low ___ Average ___ High

At what percentile are your fees compared to other practices in your area? _____% Not Sure _____.

DEMOGRAPHIC AREA:

Population of City/Town _____ Population of Drawing Area _____

Number of Dentists within 5 Mile Radius _____ Number of New Dentists in 5 Miles Radius in Last 5 Years _____

Major Employers in Area: _____

Describe any Major Economic Changes in Drawing Area: _____

Describe any other Demographic Information that may be helpful: _____

PATIENT PROFILE:

<u>SocioEconomic</u>		<u>Age</u>		<u>Zip Code(Six Largest Patient Zips)</u>	
Upper	_____ %	Under 20 Years Old	_____ %	Zip Code # _____	1 st _____ %
Upper Middle	_____ %	21 - 30 Years Old	_____ %	Zip Code # _____	2 nd _____ %
Middle	_____ %	31 - 40 Years Old	_____ %	Zip Code # _____	3 rd _____ %
Lower Middle	_____ %	41 - 50 Years Old	_____ %	Zip Code # _____	4 th _____ %
Low	_____ %	51 - 60 Years Old	_____ %	Zip Code # _____	5 th _____ %
Poverty	_____ %	61 + Years Old	_____ %	Zip Code # _____	6 th _____ %
Total	100%	Total	100%		

STAFF INFORMATION

Please list the following information by Position:

Position	Name	*Gross Annual Salary or Commission	Commission Rate, if Commissioned	Benefits (pension, health, etc.)	Full-Time / Part-Time	Year Hired	Will Stay After Sale	Is there a Signed Contract?
Office Manager								
Receptionist								
Bookkeeper								
Assistant 1								
Assistant 2								
Assistant 3								
Assistant 4								
Hygienist 1								
Hygienist 2								
Hygienist 3								
Lab Technician								
Associate								
Associate								
Other								

**Wages plus Incentives and Bonuses*

What employee fringe benefits are provided: Retirement Plan Yes No Amount Contributed \$ _____
 Health Insurance Yes No Amount Contributed \$ _____ Other Benefits _____

Do you employ family members? Yes No Are they paid? Yes No

Please give job descriptions for family members _____

Describe any unpaid family member employees, their position, schedule, duties: _____

Does your office currently meet all OSHA & CDC guidelines? Yes No

If No, explain _____

Does your office comply with provisions of your state dental practice act? Yes No

If No, explain _____

Have you received any disciplinary actions in the past seven years? Yes No

If Yes, explain _____

Have you had any suits filed against you in the past ten years? Yes No

If Yes, explain _____

Please describe any other information that would be helpful in selling your practice. Include a description of your patients and practice philosophy. (If you need additional space, use back of this page.) _____

ADDITIONAL PRACTICE INFORMATION

1. Computer Information:

Do you use:

- a. Electronic insurance filing? Yes No
- b. Send statements daily? Yes No Monthly? Yes No
- c. Insurance tracking? Yes No
- d. Treatment pending reports? Yes No
- e. Recall as part of the program? Yes No
- f. Computer scheduling? Yes No
- g. Computer maintenance agreement? Yes No

How much is paid annually for computer maintenance agreement? \$ _____

2. Do you use an outside collection agency? Yes No What agency? _____

If so, what is the arrangement? _____

3. Do you see all emergencies the same day? Yes No

4. Do you currently hold staff meetings? Yes No Who conducts? Dr. Off Mgr. Consultant

If so, how often? Daily Weekly Monthly

5. Who schedules Operative? _____ Who schedules Hygiene? _____

6. How and when are appointments confirmed: _____

7. Do you have a Staff Training Manual? Yes No

8. Do you keep employee files? Yes No

9. Technology: Do you have any of the following?

- a. Computers in the treatment rooms? Yes No
- b. Intra oral cameras? Yes No
- c. Digital radiography? Yes No
- d. Imaging software? Yes No
- e. Patient charts digitally recorded(paperless) Yes No
- e. Air abrasion system? Yes No
- f. Cameras (other) Yes No
- g. X-Ray units in each room Yes No

10. Do you have a current Employee Handbook or Personnel Policy Manual? Yes No

11. Do you perform lab functions in the office? Yes No What lab do you use? _____

12. Describe any community/civic involvement. _____

13. Lists Hobbies and special interests: _____

14. Are bonuses used as compensation in the practice? Yes No Explain Bonus plan: _____

15. Do you have a communicator system in the office? Yes No If so, what kind? _____

PRACTICE FINANCIAL DATA

DEBT AGAINST PRACTICE

To	Original Amount of Note	Balance as of Date _____	Monthly Payment	Date Note Began	Length of Note	Interest Rate

* Please include copies of each Note.

PRODUCTION

	YTD 1/1/____ To ____/____/____	Year _____	Year _____	Year _____
Doctors Production				
Hygiene Production				
Associate Production				
Total Practice Production				

Has the practice gross collections changed significantly in the last three years? YES NO

If Yes, explain _____

I acknowledge and agree that the information provided in this form is intended to be and will be disclosed to persons (including corporations, partnerships, firms and other individuals) for the purposes contemplated and that Watson, Brown & Associates, Inc. shall have no liability for any claims, demands or actions arising in connection herewith.

To the best of my knowledge, all of the information I have provided is accurate and correct.

Please Print Your Name

Signature

Date

Your Signature is required to process and complete this appraisal.

OFFICE INVENTORY LIST

PLEASE PRINT

PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
RECEPTION:				
Waiting Room Chairs				
Waiting Room Tables				
Waiting Room Lamps				
Pictures/Decorations				
Other				
Other				
Other				
BUSINESS OFFICE:				
Business Office Desk				
Business Office Chair				
Copy Machine				
File Cabinets				
Typewriter				
Computer				
Printer				
Software				
Telephone System				
Cred. Card Authorization				
Other				
Other				
PRIVATE OFFICE:				
Desk				
Chair				
Book Case				
Telephone				
Other				
Other				
MECHANICAL:				
Compressor				
Vacuum Pump				
Air Dryer				
Other				
Other				
LOUNGE:				
Refrigerator				
Table & Chairs				
Microwave				
Other				

OFFICE INVENTORY LIST – Cont'd

PLEASE PRINT

PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
X-RAY EQUIPMENT:				
Panoramic X-Ray				
Film Processor				
Developing Tank				
Duplicator				
Other				
Other				
TANKS:				
Nitrous Manifold				
System				
Tank Valves				
Other				
Other				
Other				
Other				
LAB:				
Model Trimmer				
Lathe				
Furnace				
Splash Hood w/Shield				
Vibrator				
Casting Machine				
Vacuum Forming Unit				
Porcelain & Opaque Unit				
Powder Mixer				
Articulators				
Surveyor				
Plaster Bins				
Vacuum Pump				
Lab Handpieces				
Other				
Other				
Other				
Other				
STERILIZATION:				
Auto Clave				
Ultrasonic Cleaner				
Other				
Other				
Other				

OFFICE INVENTORY LIST – Cont'd

PLEASE PRINT

PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.

If you have additional Treatment Rooms or Hygiene Rooms, you may duplicate the appropriate sheet in order to include a complete listing.

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
TREATMENT ROOM 1:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Other				
Other				
TREATMENT ROOM 2:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Other				
Other				

OFFICE INVENTORY LIST – Cont’d

PLEASE PRINT

PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.

If you have additional Treatment Rooms or Hygiene Rooms, you may duplicate the appropriate sheet in order to include a complete listing.

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
TREATMENT ROOM 3:				
Patient Chair				
Dental Units				
Doctor’s Stool				
Assistant’s Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Other				
Other				
TREATMENT ROOM 4:				
Patient Chair				
Dental Units				
Doctor’s Stool				
Assistant’s Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Other				
Other				

OFFICE INVENTORY LIST – Cont'd

PLEASE PRINT

PROVIDE THE DEPRECIATION SCHEDULE WHICH INCLUDES THE COST AND DATE OF PURCHASE.

If you have additional Treatment Rooms or Hygiene Rooms, you may duplicate the appropriate sheet in order to include a complete listing.

	Quantity	Manufacturer	*Approx. Date of Purchase	Description
HYGIENE ROOM 1:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				
HYGIENE ROOM 2:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				

OFFICE INVENTORY LIST – Cont'd

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If you have additional Treatment Rooms or Hygiene Rooms, you may duplicate the appropriate sheet in order to include a complete listing.

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Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				
HYGIENE ROOM 4:				
Patient Chair				
Dental Units				
Doctor's Stool				
Assistant's Stool				
Lights				
Mobile Carts				
Prophy Jet				
Handpieces:				
High Speed				
Low Speed				
Other				
Curing Light				
Cabinets				
X-Ray Units				
X-Ray View Box				
Nitrous Flow Meter				
Amalgamator				
Cavitron				
Other				

EXCLUDED ITEMS LIST

Please list all items that will be excluded from the sale.

#	DESCRIPTION OF ITEM
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

Please Sketch or Attach an Office Layout:

WATSON, BROWN & ASSOCIATES, INC.

RELEASE FORM

I have engaged the services of Watson, Brown & Associates, Inc. to prepare a valuation of my dental practice. It may be necessary for Dr. Terry Watson, Frank J. Brown, J.D., LL.M.(taxation) or one of their representatives to contact you for accounting and tax information that is needed in the preparation of the valuation.

Please consider this letter authorization for release of my information by

_____ to Watson, Brown &
(Accounting Firm)

Associates, Inc., and its representatives.

Name Signed

Name Printed

Date