



DENTAL MANAGEMENT INSTITUTE
Doctors Helping Doctors and Their Teams™

PRACTICE SURVEY FOR YOUR PRACTICE ANALYSIS

PLEASE ANSWER THE FOLLOWING QUESTIONS. ATTACH ADDITIONAL PAGES IF NEEDED. THIS INFORMATION REMAINS CONFIDENTIAL.

1. **What are the biggest challenges you face in your practice now?**

2. **In the past, have you utilized any practice management consulting? If yes, please describe your experience and results.**



3. What are your office hours?

M_____ T_____ W_____ Th_____ F_____ S_____

4. How many days per week does the Doctor work? How many days per week does the Hygienist(s) work?

Doctor_____

Hyg_____

5. List your staff and the positions they hold in your office.

6. How many active patients are in your practice (been in the office in the last 2 years)?

7. Have you done any marketing or advertising for your practice? If yes describe what you have done and what were your results.



8. **Do you have an internal marketing program in your office? If yes, please describe your program and results.**

9. **What is your percentage of treatment plan acceptance?**

10. **Do you have a written financial agreement for patient payments? If yes, please attach a copy.**

11. **Who makes financial arrangements with the patients in your office?**



12. **Do you have intra-oral photography? If yes, do you utilize it routinely?**

13. **Do you utilize targets and goals with your team? If yes, are team members fully aware of what they are?**

14. **Do you have a morning meeting before the start of each day?**

15.. **Is there accountability with your team for what they do daily? If yes, how do you measure it?**

16. **Do you have incentives or bonuses for your team? If yes, please describe them.**



17. **Do you know your hygiene retention rate (percentage of patients who return regularly for recall). If yes, what is it?**

Please utilize the chart below for the last 3 questions.

18. **Please fill in your production totals by month for the last 6 months, by month.**

19. **Please fill in your collection totals by month for the last 6 months, by month.**

20. **Please fill in your new patient totals by month for the last 6 months, by month.**

	Month 6 Oldest	Month 5	Month 4	Month 3	Month 2	Last Month
Production						
Collection						
New Pat.						



END OF SURVEY

Practice Name: _____

Doctor: _____

Date: _____

**Thank you! You are one step closer to seeing improvement in your practice.
We can help you!**

Please email the completed survey to contactus@dentalmanagementinstitute.com and make sure we have an appointment scheduled for your follow up to discuss the analysis of your practice.



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