

DATE: \_\_\_\_\_

## *Practice Profile*

Name: \_\_\_\_\_

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

Name of Practice: \_\_\_\_\_

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

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

Backline: \_\_\_\_\_ Home: \_\_\_\_\_

\_\_\_\_\_

E-mail: \_\_\_\_\_ Cell: \_\_\_\_\_

1. What are your immediate goals for your Practice? \_\_\_\_\_

### IMMEDIATE GOALS AND PRIORITIES

- |   |   |
|---|---|
| <input type="checkbox"/> Team Building/Strategic Planning<br><input type="checkbox"/> Hygiene Department Refinement<br><input type="checkbox"/> Restorative/Aesthetic Enrollment<br><input type="checkbox"/> Refinement of Communication<br><input type="checkbox"/> Systems – Practice Management<br><input type="checkbox"/> Clinical Proficiency Training for Microultrasonics<br><input type="checkbox"/> Clinical Laser Training | <input type="checkbox"/> Customized Administrative Support<br><input type="checkbox"/> Refinement of Written Financial Arrangement<br><input type="checkbox"/> Patient Nutrition Education<br><input type="checkbox"/> Transitions/Restructure Job Description<br><input type="checkbox"/> Building New Office/Renovation/Adding Operatory<br><input type="checkbox"/> Wellness and Oral Systemic Link Update<br><input type="checkbox"/> Biophotonic Scanner Integration |
|---|---|

2.a. Have you, or are you presently working with a dental management, technology consultant or training institute? \_\_\_\_\_  
 If yes, please provide name: \_\_\_\_\_

2.b. Have you, or are you presently attending an institute or continuum to support advanced education for your restorative practice? \_\_\_\_\_  
 If yes, please provide name: \_\_\_\_\_

2.c. What study club do you belong to? \_\_\_\_\_

3. Do you have a clearly defined practice philosophy that each team member supports? \_\_\_\_\_

4. Are your hygienists communicating restorative needs 100% of the time? \_\_\_\_\_

5. Is the intraoral camera used 100% of the time for all patients? \_\_\_\_\_

6. Does your team discover and communicate aesthetic possibilities to 100% of your patients? \_\_\_\_\_

7. Does your team utilize open-ended questions to increase value and increase case acceptance? \_\_\_\_\_

8. Do you have a systematic and effective doctor/hygiene periodic exam that increases case acceptance? \_\_\_\_\_

9. Do you have more than one hygienist (Yes/No) and do they have continuity with all practice procedures? \_\_\_\_\_

10. Are you confident that your current clinical protocols and technology are up to date with most recent research?  
Restorative/Aesthetics \_\_\_\_\_ Hygiene Clinical Delivery \_\_\_\_\_

11. How many total operatories do you have? \_\_\_\_\_ Do you plan to expand? \_\_\_\_\_

12. Do you have and/or use the following:

Micro-ultrasonics	No	Yes (Have)	Yes (Use)	
Laser	No	Yes (Have)	Yes (Use)	
Intraoral Camera	No	Yes (Have)	Yes (Use)	
Educational Technology Program	No	Yes (Have)	Yes (Use)	
Digital Radiography	No	Yes (Have)	Yes (Use)	
Caries Diagnostic Technology	No	Yes (Have)	Yes (Use)	
Arestin	No	Yes (Have)	Yes (Use)	
Atridox	No	Yes (Have)	Yes (Use)	
Molecular or Genetic Diagnostic Testing	No	Yes (Have)	Yes (Use)	
Periostat	No	Yes (Have)	Yes (Use)	
Waterpik	No	Yes (Have)	Yes (Use)	Dispense _____ Yes
Power Toothbrush	No	Yes (Have)	Yes (Use)	Dispense _____ Yes

13. Do you have tracking and systems in place to monitor diagnosis, production, case acceptance, and profits in the practice per department/case acceptance? \_\_\_\_\_

14. Does your team consider their dental career an exciting opportunity for personal and professional growth? \_\_\_\_\_

15. Are cancellations an issue? \_\_\_\_\_

16. How many active (within the last 12 months) patients do you have in recall? \_\_\_\_\_

17. List your current fees for the following procedures. How many of the following procedures were provided last year:

	<u>Fee</u>	<u># Provided</u>
Root Planing/Perio Therapy (4341)	\$ _____	/ _____
Root Planing/Perio Therapy 1-3 Teeth (4342)	\$ _____	/ _____
Continuing Care/Routine Prophy (1110)	\$ _____	/ _____
Perio Maint./Supportive Perio Therapy (4910)	\$ _____	/ _____
Arestin (4381)	\$ _____	/ _____
Molecular Testing	\$ _____	/ _____
Crowns	\$ _____	/ _____
Veneers	\$ _____	/ _____
Fillings	\$ _____	/ _____

Current # of hygiene days per week \_\_\_\_\_ # of patients seen per day \_\_\_\_\_

Current Adult time allotment:

Prophy	_____
Root Planing	_____
Perio Maintenance	_____

18. What does your practice gross per month? \$ \_\_\_\_\_

19. What is your current hygiene production per day with / without X-rays?  
(Please indicate whether X-rays are included)

Per day \_\_\_\_\_ Per month \_\_\_\_\_

*~Administrative Department Analysis~*

1. Do you take insurance assignments? If so, please list insurance companies. \_\_\_\_\_  
\_\_\_\_\_
2. Does your team overcome insurance questions effectively by communicating the value of dentistry?  
\_\_\_\_\_
3. Does your practice utilize block scheduling for the doctor's schedule and for the hygiene schedule?  
\_\_\_\_\_
4. How many new patients are you attracting per month? \_\_\_\_\_
5. How much time is allotted for the new patient? \_\_\_\_\_  
Who is doing the following:  
Interview (the patient's story) \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Financial Presentation \_\_\_\_\_  
Treatment Presentation (the value of the dentistry) \_\_\_\_\_
6. Does the new patient visit include a prophylaxis with the hygienist? \_\_\_\_\_
7. What percentage of case acceptance do you average with new patient diagnosis? \_\_\_\_\_
8. Do you utilize a pending system or "tickler file" to follow up with outstanding treatment? \_\_\_\_\_  
Who is responsible for the follow-up? \_\_\_\_\_  
How is it monitored? \_\_\_\_\_
9. Do you currently have regular team meetings? \_\_\_\_\_  
Do you consider the meetings to be productive? \_\_\_\_\_
10. Do you have daily patient care meetings or "huddles" each day? \_\_\_\_\_  
How long do they last? \_\_\_\_\_  
Does the entire team attend? \_\_\_\_\_

***Please Fax Completed Practice Profile to (760) 692-2134***

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