THE JP INSTITUTE
CERTIFICATION•PRODUCTS•CONSULTING

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

- ☐ *Team Building/Strategic Planning*
- ☐ *Hygiene Department Refinement*
- ☐ *Aesthetic Enrollment*
- ☐ *Refinement of Communication*
- ☐ *Systems – Organizational Management for Profit*
- ☐ *Clinical Proficiency Training for Microultrasonics*
- ☐ *Clinical Laser or Clinical Perioscopy Training*
- ☐ *Customized Administrative Support*
- ☐ *Refinement of Written Financial Arrangement*
- ☐ *Insurance Independence*
- ☐ *Transitions/Restructure Job Description*
- ☐ *Building New Office/Renovation/Adding Operatory*

2. *Have you, or are you presently working with a dental management consultant?* ___________
If yes, please provide name: ____

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) _____*
Perioscopy	*No____ Yes (Have)____ Yes (Use) _____*
Casey Systems	*No____ Yes (Have)____ Yes (Use) _____*
Digital Radiography	*No____ Yes (Have)____ Yes (Use) _____*
Difoti	*No____ Yes (Have)____ Yes (Use) _____*
Diagnodent	*No____ Yes (Have)____ Yes (Use) _____*
Power Toothbrush	*No____ Yes (Have)____ Yes (Use) _____*
Arestin	*No____ Yes (Have)____ Yes (Use) _____*
Atridox	*No____ Yes (Have)____ Yes (Use) _____*
Periostat	*No____ Yes (Have)____ Yes (Use) _____*

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:*

	Fee	*# Provided*
Root Planing/Perio Therapy (4341)	*$______________________*	*/______________________*
Root Planing/Perio Therapy 1-3 Teeth (4342)	*$______________________*	*/______________________*
Continuing Care/Routine Prophy (1110)	*$______________________*	*/______________________*
Perio Maint./Supportive Perio Thearpy (4910)	*$______________________*	*/______________________*
Arestin (4381)	*$______________________*	*/______________________*
Crowns	*$______________________*	*/______________________*
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 100 % of your patients receive a written financial arrangement with at least three options for payment?____*

2. *Do you offer third party financing?________If so, what kind of financing do you offer?___________*
____

3. *What are your total accounts receivable? 30 days_________ 60 days_________ 90 days__________*

~Administrative Department Analysis (Continued) ~

4. *Do you take insurance assignments? If so, please list insurance companies.* ____________________
____

5. *Does your Team overcome insurance questions effectively by communicating the value of dentistry?*
____

6. *Does your practice utilize block scheduling for the doctor's schedule and for the hygiene schedule?*
____

7. *How many new patients are you attracting per month?*______________________________________

8. *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) ________________________________

9. *Does the new patient visit include a prophylaxis with the hygienist?* __________________________

10. *What percentage of case acceptance do you average with new patient diagnosis?*________________

11. *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? ____

12. *Do you currently have regular Team meetings?*____
   Do you consider the meetings to be productive? ____

13. *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) 730–9138

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