Krystal Clear
COACHING
Coaching you clear of the obstacles in your path to success

Section 1: Basic Practice Information

Practice Name: _____

Mailing Address: _____

Street Address Apt, Suite, Bldg. (if different): _____

City, State: _____Zip Code: _____

Phone: (____)_____-_____ Cell : (____)_____-_____ Fax: (____)_____-_____

Office Email address: _____

Doctor's Email address: _____

Do you have a website? YES____ NO ____

URL: http://_____

What year did you complete your dental training? _____

Are you a general practitioner or a specialist? _____

What Procedures are performed in the practice (Check all that apply and circle or specify):

___ Pediatric dentistry ___ Endodontics ___ Hygiene (Performed by the Dentist or a Hygienist)

___ Do you sell Hygiene support products? (eg… Peridex, Clinpro, Arestin….) Please list: _____

_____

___Periodontal Treatments (Specify) _____

_____

___ Fillings (Composite, Amalgam) ___Bone Grafts ___Implants Placement ___Implant Restoration

___ Orthodontics (Traditional, Invisalign, ClearCorrect) ___ Laser

___ Extractions ___ 3rd molar Extractions ___ Oral Sedation ___ IV Conscious Sedation___ Nitrous

___ Crowns ___Veneers ___ Occlusal Guards ___ Whitening (Take Home, Chair Side) ___ Dentures/ Partials

Other_____

_____

If a specialist, what is your specialty? _____

How long have you been in your current practice? _____

In your current practice, are you the Associate, a Partner, or another position? _____

What Practice software do you use? (Eaglesoft, Dentrix….) _____

How effectively are you and your staff utilizing it? _____

What type of charting are you using? ___ Digital ___Paper ___Both

What type of x-rays are you using? ___Digital ___Film

Do you use an appointment reminder system?

YES ____ NO ____

If so, which one? Lighthouse 360, Smile Reminders, DemandForce, Revenue Well, Other _____

Do you use any outside financing?

YES ____ NO ____

If so, which ones? CareCredit, Simple Pay, Smart Finance, Other_____

How fluent is your team in presenting these financial options?_____

How well is third party financing currently being utilized in the practice?_____

Please list any additional support services you use and their names: eg…social media services, website monitoring, Insurance Answers Plus, Collection agencies, etc…_____

_____

What are your office hours? (Please be specific.)

MON: _____ to _____

TUES: _____ to _____

WED: _____ to _____

THURS: _____ to _____

FRI: _____ to _____

SAT: _____ to _____

What are your total hours open for business each week? _____

Section 2: General

Is your schedule unpredictable and do you have days where the time was never filled on the schedule?

YES ____ NO____

Do you have written cancelation policies?

YES____ NO____

Are patients getting confirmed and still breaking their appointments?

YES____ NO____

Are patients with incomplete treatment being contacted on a regular basis?

YES____ NO____

Do you have Written Job Descriptions and Responsibilities with clear, measurable benchmarks?

YES____ NO____

How often are you completing team OSHA training? _____

How is your documentation?_____

Are you prepared in case of an OSHA audit?

YES____ NO____

Do you have established Goals?

YES ____ NO____

If yes, what are they? Daily $_____Monthly $_____ Yearly $_____

Does your team know what they are?

YES ____ NO____

Are you producing and collecting according to your goals?

YES____ NO____

Are you achieving your personal financial goals?

YES____ NO____

Are you in control of your practice and its future?

YES____ NO____

Do you look forward to going to the office?

YES____ NO____

Why *or* Why not?_____

_____

What would make work more enjoyable?_____

_____

Is your collection to production ratio at least 98%?

YES____ NO____

Do you rarely get complaints about mistakes on patient's accounts?

YES____ NO____

Does your team know exactly what you want from them?

YES____ NO____

Do you have time to train your team?

YES____NO____

Are newly hired team members trained quickly and soon functioning well on their jobs?

YES____ NO____

Do you know how productive your team is on an individual basis?

YES____ NO____

Is team morale in your practice very high?

YES____ NO____

Is there a high rate of team member turnover?

YES____ NO____

Is there conflict between team members?

YES____ NO____

How often are you holding team meetings? _____

Do you feel you and your team use effective, elegant communication:

Among yourselves? YES____ NO____

With patients? YES____ NO____

Are you holding daily morning huddles?

YES____ NO____

Do you wish they were more productive?

YES____ NO____

Is your office in a stand-alone building?

YES____ NO____

Has your production leveled off or declined?

YES____ NO____

Is your office sign visible to passersby?

YES____ NO____

Have you done any marketing to attract new patients?

YES____ NO____

If so, what type specifically? _____

What was your level of success?_____

How were you tracking and measuring the results?_____

_____

What is the number of dentists per capital in your town/city? _____

Section 3: Statistics

What was your total office production last year? $_____

What percentage of total office production were hygiene procedures? %_____

What were your total office collections last year? $_____

What is the average percentage of production collected each month? %_____

Number of Administrative/Front Desk Team Members:

FULL TIME: _____

PART TIME: _____

Specify Names and Positions:

_____

_____

# of Hygienists:

FULL TIME: _____

PART TIME: _____

# of Technical Team Members (not including Hygienists):

FULL TIME: _____

PART TIME: _____

# of Doctors in the practice: _____

# of Doctor Treatment Rooms: _____ Is there room for growth? _____

# of Doctor Hours Per Week: _____

# of Hygiene Treatment Rooms: _____

# of Combined Hygiene Days Worked Per Week: _____ Assisted or Unassisted?

# of New Patients Per Month: _____

Do Patients have to wait 3 or more weeks for an appointment for treatment with the Doctor?

YES____ NO____

Do Patients have to wait 3 or more weeks for an appointment for a cleaning with the Hygienist?

YES____ NO____

Do **New Patients** have to wait 3 or more weeks for an appointment?

YES____ NO____ How Long? _____

What is your policy for handling **New Patient** appointments? _____

_____

How far out are emergency/problem focused patients scheduled? _____

What is your policy for handling emergency patient appointments for patients of record? _____

_____

What is your policy for handling emergency patient appointments for **New Patients**? _____

_____

How many patients have not been in for a cleaning in 6 months or longer? Go back 3 years.

_____

Explain your current re-care system. _____

_____

Who's responsibility is it currently? _____

What % of your Accounts Receivable balance is over 90 days? %_____

What is your total outstanding Accounts Receivable balance? $_____

Explain your current in house collections system. _____

_____

Do you accept insurance?

YES____ NO____

How many Insurance plans are you contracted with? #_____

Please list them along with contracting status. (PPO, Premier…..) _____

_____

What is your total Outstanding Insurance Claims over 90+ days? #_____ $_____

What is your Total Outstanding Insurance Claims including current? #_____ $_____

When were your insurance fee schedules last updated? _____

When were your standard fees last increased? _____

Do you bill insurance at ***your full standard fee*** or ***their negotiated fees***? (circle one)

Are Hygiene salaries more than 33% of their production?

YES____ NO____

What percentage of your collections was spent on the following last year:

Facility Cost? %_____

Total Team Compensation (including benefits)? %_____

Continuing Education? %_____

Marketing? %_____

Laboratory Cost? %_____

Office Administrative Supplies? %_____

Technical Dental Supplies? %_____

What is your overhead percentage (all expenses, except Dr.'s salary)? % _____

Please explain how the different Team Members, Hygienists and Associates are compensated. (eg… hourly, bonuses, salary, commission)_____

_____

Section 4: Staff

Does your spouse work with you in the practice?

YES ____ NO ____

If so, what is your spouse's job position and duties?

_ _____

Is your spouse full-time or part-time?

FULL _____ PART _____

Do you have trouble finding/hiring qualified team members?

YES ____ NO ____

Do you have trouble retaining team members?

YES ____ NO ____

Do you have a Policy & Procedures manual for the team?

YES ____ NO ____

In order, please list what you perceive to be your most pressing areas of concern **NOW**.

1. _____

_____

2. _____

_____

3. _____

_____

In order, please list your **three main goals.**

1. _____

_____

2. _____

_____

3. _____

_____

Section 5: Prior Consulting

Have you ever had a practice management consultant?

YES ____ NO ____

If so, describe the type of program (consulting, seminars, one-on-one, on-site, etc.)

_____

_____

Were you satisfied with the results?

YES ____ NO ____

What went well with your previous coaching? _____

_____

_____

What techniques and tools are you currently utilizing in the practice from you previous coaching?_____

_____

_____

Section 6: Retirement

Do you have retirement goals?

YES ____ NO ____

If so, what are they?

_____

Do you feel you are on track to meeting them?

YES ____ NO ____

Is there something you feel you should do to be more on track?

YES ____ NO ____

If so, what might that be? _____

_____

Section 7: Conclusion

Please give us a time to contact you by noting your preferences below (time and weekday, please).

_____

What method of contact do you initially prefer?

___ Text ___ Email ___ Cell Phone ___ Office Phone ___ Home Phone ( )_____-_____

What methods of contact do you typically prefer on an ongoing basis?

___ Text ___ Email ___ Cell Phone ___ Office Phone ___ Home Phone ( )_____-_____

List any additional information that may help us better understand you and your practice and your goals:

_____

_____

_____

_____

_____

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_____

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_____

_____

How can we best help you? Please be specific.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Success is directly dependent on the 'coach-ability' of you and your team! How coachable are you?

What obstacles do you see in your path to success?

Please include copies of the following information:

1. _____ Accounts Receivable report (AR)
2. _____ AR Credits Only Report
3. _____ Outstanding Insurance Claims report
4. _____ Detailed End of Month (EOM)Reports for last 2 years and this year showing:
    a. _____ Production detailed
    b. _____ Collections detailed
    c. _____ Adjustments detailed
5. _____ End of Year (EOY)Reports for past 2 years
6. _____ Current Office Standard Fee Schedule
7. _____ Current Insurance Fee Schedules for all Contracting Insurance Plans
8. _____ Procedure Code Analysis report, showing 1 year of procedure code history with totals in # and $
9. _____ Practice Analysis report showing:
    a. _____ # of active patients
    b. _____ # of patients with appointments
    c. _____ Breakdown of patient demographics, # with insurance, age, etc…
10. _____ Copies of the Schedule for :
    a. _____ Last Month,
    b. _____ This Month
    c. _____ Next Month
    d. _____ Five Months Out
11. _____ End of Year P&L's for the last 2 years
12. _____ Monthly P&L's for this year
13. _____ Copy of current employee Policy & Procedures manual
14. _____ Unscheduled Treatment (with comparison if available) go back 3 years
15. _____ Continuing Care Report showing all patients without a re-care appointment, past due, current due and future due (go back 3 years)