Dental Excellence Advisory
Helping Dental Practices Grow...
one tooth, one quadrant & one arch at a time.

Dental Excellence Advisory
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DOCTOR QUESTIONNAIRE

Dr._____

Name of Practice_____

Office Address_____

Work Phone_____ Work Fax_____

Cell Phone_____ How did you hear about us? _____

Personal Email_____

Office Email_____

Website_____

PRACTICE DATA

Type of Practice_____ Number of active patients _____

Of Staff: Doctors _____ Hygienists _____ Administrative _____ Assistants _____

Of Treatment Rooms: Doctor _____ Hygiene _____ Consultation _____

Length of time in practice _____ At this location _____

Schedule: Mon _____ Tues _____ Weds _____ Thurs _____
Fri _____ Sat _____ Sun _____

Do you participate in any insurance plans? Which ones?

DESIRED CHANGES

What are your top 3 concerns for your practice?

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____

Other concerns: _____
_____
_____

GOALS AND MONITORING

What are your goals for the practice and yourself?_____
_____

What are the things that are preventing you from attaining those goals? _____
_____
_____

Does your team know and understand the goals of the practice? _____

Are you monitoring the important practice vital signs monthly and discussing them at team meetings? _____

Do you feel that an incentive bonus system would help to motivate your team to help you achieve these goals? _____

In how many years would you like to retire?_____

PRODUCTION

Are you satisfied with how your administrative team is scheduling you each day?
_____
_____

What's not working? _____
_____
_____

Does your administrative team schedule for a production goal each day for each Producer (Doctor & Hygiene)? _____

Are you attaining these goals? _____

Does your administrative team have an effective system for tracking treatment that has been diagnosed, but not completed? _____

Are you happy with the management of new patients (Initial telephone contact, comprehensive exam, and treatment acceptance)? _____

If not, what would you like to improve? _____
_____

Are you happy with the hygiene production? _____

Is 33% of your hygiene production resulting from periodontal procedures? _____

Is your hygiene department generating large amounts of cosmetic and quadrant restorative procedures for the doctor? _____

When was the last time you analyzed your fees and/or had a fee increase? _____

COLLECTIONS / ACCOUNTS RECEIVABLE

Are financial arrangements properly offered, set up, and followed through? _____

Are your over-the-counter collections at least 50% of production? _____

Do you promote 3rd party financing (i.e. Care Credit) to your patients? _____

Would you like to become less dependent on insurance companies and managed care plans? _____

CUSTOMER SERVICE AND MARKETING

Do you feel the team creates an exceptional patient experience? _____
_____

Is there anything about this that you would like to change? _____
_____

Do you feel that your administrative and clinical team members have effective communication skills with the patients (Handling dissatisfied patients, explaining dentistry and answering clinical questions, marketing your services, and building up the image of the practice)? _____
_____
_____

Does your team create a “Wow” experience that patients talk about to others, such as friends, neighbors, and coworkers? _____
_____
_____

What high-tech equipment do you have in your office (ex: intra-oral camera, laser, Cerec)? _____
_____

PRACTICE BUSINESS PLAN

Is there a monthly budget to follow for office supplies and dental supplies? _____

Do you have an annual budget (assigned percentage and dollar amounts) for the different expense areas in your overhead costs? _____

Indicate your fees for: Crown _____ Quadrant of Root Planing _____

1-surface Resin _____ 2-Surface Resin _____ 3-surface Resin _____

LEADERSHIP

Do you hold morning meetings every day? _____ Are they effective? _____
If not, why? _____

How often are team meetings held? _____

Do you feel that they are as effective as they could be? _____
If not, why? _____

Has conflict between team members caused turmoil in the office? _____
If yes, please explain. _____

Do you give performance reviews? _____ If not, why? _____
_____

TEAM

Rate your level of satisfaction with each team member's JOB PERFORMANCE.

NAME	POSITION	EXCELLENT	AVERAGE	POOR

List each team member and what you consider their strengths and weaknesses.

NAME	STRENGTHS	WEAKNESSES

Note specific concerns about any team member and the way that they are performing their job. _____

_____

_____

CONSULTING EXPERIENCE

Have you ever worked with a practice management consultant before? _____

If yes, who and when? _____

What were your successes? _____

_____

_____

What didn't work? _____

_____

_____

List the top 5 things that you would like Dental Excellence Advisory to help you accomplish in your practice.

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

On a scale of 1-10: (1= highly unlikely, 10= highly likely)

How important is it to you to commit to some level of change for the growth of your practice?

1 2 3 4 5 6 7 8 9 10

How confident are you that you could implement strategies or systems to make the necessary changes happen?

1 2 3 4 5 6 7 8 9 10

How ready are you to embark on a course to, actually, make some changes for the benefit of your practice?

1 2 3 4 5 6 7 8 9 10

Please feel free to attach any additional comments/thoughts that you would like to share. All information submitted will be held in the strictest confidence.

Dr. Signature_____ Date_____