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

Dental Excellence Advisory
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OFFICE MANAGER QUESTIONNAIRE

Name_____

Name of Practice_____

Your work schedule: Mon____Tue____Wed____Thur____Fri____Sat____Sun___

How do you prefer to be contacted to schedule calls with our coaches?
____ at work _____ on cell phone/texting ____email?

Work #_____ Cell #_____ Email_____

How long have you worked in this practice? _____ How long in Dentistry? _____

What are the 3 things you like most about your practice?

1. _____

2. _____

3. _____

What are your top 4 concerns for your practice?

1. _____

2. _____

3. _____

4. _____

What are the top 3 things you would like to change for your practice?

1. _____

2. _____

3. _____

What are the obstacles to making these changes?

1. _____

2. _____

3. _____

How often are team meetings held? _____ Are they effective? _____

Has conflict between team members caused turmoil in the office? _____

Do you feel that gossip sometimes interferes with the culture of the office?_____

Explain: _____

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? _____

TEAM

Rate the morale of the team: HIGH MODERATE LOW

Rate YOUR level of enthusiasm in the office: HIGH MODERATE LOW

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. _____

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.

Signature_____ Date_____

OFFICE INFORMATION

Name of practice management software _____

Please check off what software is being used for:
_____ scheduling
_____ treatment planning
_____ reports (ex: aging, production, insurance, referral)

Is the office paperless? _____ If not, are there any plans of doing so? _____

Do you use a scanner? _____ Are there computers in each treatment room? _____

Is the practice management software installed in each computer? _____

Please check off which technologies/devices are used in your practice:
_____ digital radiography
_____ panoramic
_____ CT Scan-3D Imaging
_____ E4D/Cadcam
_____ In-office milling
_____ Oral Cancer Screening device
_____ Diode Laser

List the dental products recommended to patients:
_____
_____

List the services provided by the hygienists:
_____ prophy
_____ full mouth debridement
_____ periodontal maintenance
_____ gingivitis code 4346
_____ localized root planing/scaling
_____ quadrant root planing/scaling
_____ Laser Bacterial Reduction
_____ arestin therapy
_____ sealants
_____ fluoride
_____ irrigation
_____ other: please list _____

Practice Hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____

Office email: _____

We may need to connect to your Wifi when we are at the office. Can you please provide:
Wifi _____
Password _____