BETTE E. ROBIN, DDS, JD
SELECT PRACTICE SERVICES, INCORPORATED

APPROXIMATE PRACTICE VALUE WORKSHEET

Your Name: _____

Your Address: _____

_____

Your Email Address: _____

Confidential Telephone Number: _____

Type of practice: _____
(Indicate general or specify specialty type)

Collections, this year to date: _____ As of date: _____

Collections for last year, as shown on your tax return: _____

Insurance Composition of practice:

Private: ____% Indemnity: ____% PPO: ____% HMO: ____% Medi-Cal: ____%

How long have you been practicing in this location? _____

Number of operatories: _____

Professional building or commercial center? _____

Square footage of practice: _____ Lease payment: _____

Number of years remaining on lease/options: _____

Number of days you work per week: _____

Number of employees, in what positions: _____

_____

_____

Please complete and fax this worksheet to Dr. Robin at 714-333-4394, or email the information to DrRobin@BetteRobin.com. Dr. Robin will call you at the telephone number you provide within two business days.