

**APPROXIMATE PRACTICE VALUE WORKSHEET**

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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.*

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