



Part I: Dental Practice Situation Analysis

*Please answer as thoroughly as possible, while remembering
it is not necessary to answer all questions.*

If any questions do not apply please indicate this by entering D.N.A.

1. Practice Owner's Name:
2. If someone other than Practice Owner is completing this Analysis, please confirm you are authorized to act as Practice Owner's representative by entering your name here:
3. Which best describes your Practice (e.g. General, Pediatric, Periodontal, Orthodontic, Endodontic, Prosthodontic, Oral Surgeon, etc.)?
4. What specific services do you offer?
 - a. Velscope/Vizilite/other oral cancer detection device:
 - b. Invisalign:
 - c. Intraoral Camera:
 - d. Laser (Soft/Hard Tissue):
 - e. Digital Xray:
 - f. Porcelain Veneers:
 - g. No Prep Veneers e.g. Lumineers:
 - h. Cerec:
 - i. Cosmetic Dentistry:
 - j. Zoom!:
 - k. Bright Smile:
 - l. Sedation Dentistry:
 - m. Treatment of Sleep Disorders e.g. SomnoMed:
 - n. TMJ:
 - o. Dentures:
 - p. Eating Disorder:
 - q. Mercury Free Amalgam Removal:
 - r. Specialty Mouthguard:
 - s. Implants (placement/restoration):
 - t. Emergency Dentistry:
 - u. Other:
 - v. Other:
 - w. Other:
 - x. On Line "paperless" Patient Services
 - i. HIPAA Compliant Forms Submittal
 - ii. Appointment Scheduling

iii. Payment/Account Inquiries

- y. OTHER:
5. How many full-time dentists does your Practice employ?
 6. What are their Specialties?
 7. How many part-time dentists does your Practice employ?
 8. What are their Specialties?
 9. How many operatories does your Practice have?
 10. Tell us about your Team (name, title, tenure, etc.):
-
11. For how many DAYS per MONTH is your Practice open?
 12. For how many HOURS per DAY (average) is your Practice open?
 13. On average, how many TOTAL Patients does your Practice see in a typical month?
 14. How many NEW patients does your Practice see each month?
 15. One year from now, how many MORE patients per month would you like your Practice to see?
 16. Please share your degree of satisfaction with the 'quality' of your typical new patient. For instance, does he/she seem to understand, value, and accept your treatment recommendations?
 17. **IMPORTANT: Please complete this section as thoroughly as possible as it will be used to identify and develop your Unique and Distinguishable Offerings:**
 - a. **Who We Are** (as much detail as possible about you, your team, your practice philosophy, how you differ from other practices, etc.)
 - b. **What We Do** (type(s) of dentistry your practice. Be sure to phrase in terms of attributes/features (what you do) AND BENEFITS (why patients care)
 - c. **For Whom Do We Do It** (be specific about who is your 'ideal patient' in terms of: geography i.e. what towns, neighborhoods, communities, etc. you serve, demographics e.g. families, income, lifestyle (health conscious, appearance conscious, comfort conscious, etc.)
 18. How significant are the following sources of new patients for your Practice?
(1 = Very 2 = Somewhat 3 = Not Very 4 = Not At All)
 - a. Patient Referral:
 - b. Dentist Referral:
 - c. Direct Mail To New Residents:
 - d. Direct Mail To Area Residents:
 - e. Direct Mail To Area Businesses:
 - f. Yellow Pages:
 - g. Newspaper:
 - h. Radio:
 - i. TV:
 - j. Specialty Magazine:
 - k. On Hold Messages:
 - l. Public Relations e.g. Press Releases:
 - m. Charitable e.g. Cause-Related Marketing:
 - n. Health Fairs:

- o. Internet e.g. Website, Pay Per Click, SEO, Inbound Links, etc.:
 - p. Exterior Signage/Drive By Traffic:
 - q. Dental Insurance Directs Patients To My Practice:
 - r. Physician Referral:
 - s. Other (please explain):
19. What is your dental license identification number? This is necessary to be listed in the pertinent search directories.
-
20. Does your Practice have a formal Dentistry Marketing Plan?
21. What Patient Source Tracking Methodologies, if any, do you employ?
22. Based on your perception of other Practices with which you compete, please rate your Practice in the following areas (1 = Very 2 = Somewhat 3 = Not Very 4 = Not At All)
- a. Latest technology:
 - b. Warm & caring environment:
 - c. Staff training and competence:
 - d. Quality of procedures performed:
 - e. Patient satisfaction level:
 - f. There is increasing evidence that dental health has a profound influence on systemic, or overall, health. Does your Practice emphasize this in the services it provides or its communications?
23. If you answered yes to the previous question, please explain how you communicate your 'systemic approach to oral health' to your patients
24. How would you describe your Practice's Professional Identity (logo and brand)?
25. Do you 'give back,' that is, do you engage in philanthropic activities?
26. If you answered yes to the previous question, please share the specific philanthropic activities in which you are engaged, as well as how these are promoted
27. Is the Practice's currently involved in Public Relations and Community Outreach?
28. During Practice hours, please share how long it takes to get to your office (by most common means e.g. walking or driving) within the following radii (feel free to elaborate if e.g. it depends upon the time of day, direction of travel, etc.):
- a. .5 mile:
 - b. 1 mile:
 - c. 2 miles:
 - d. 5 miles:
 - e. 10 miles:

Part II: Dental Practice Situation Analysis, Page 4

29. What is the Ethnicity of your Patient Base?
 - a. African American:
 - b. Asian:
 - c. Caucasian:
 - d. Hispanic:
 - e. Eastern European:
 - f. Other:
30. What languages are spoken by your patients?
31. If you have Communications Materials, please indicate which, and forward them to us, either by email or regular mail, so we may better understand the present state of your Practice Branding including, but not limited to:

- *Letterhead
- *Envelope
- *Business Card
- *Appointment Reminder Card
- *New Patient Packet &Practice Brochure
- *Prospective Patient Mailer
- *Photograph of sign(s)

Part II: Analysis of Internet Marketing Performance (AIM^P)

1. Practitioner's Name:

2. What is/are goal(s) for your website?

3. Do you have a Facebook account?

4. Do you have a Twitter account?

5. Do you have a YouTube account?

6. If there are websites on which you wish to rank other than Google, Yahoo and Bing, please note them below:

7. What do you use to track users on your site?

Part II: Dental Practice Situation Analysis, Page 5

8. Have you done any SEO previously? If so, what and when?

9. Have you done any website testing?

10. What action(s) would you like website visitors to take?

11. If you have a Google account, please provide access information i.e. username and password (this allows us to see what has been submitted to Google).

12. Have you done any Pay Per Click advertising? If so, what and when?

13. Do you plan on adding any content to your site?

14. Are there any keywords you would like to rank for?

15. What is your dental license identification number? This is necessary to be listed in the pertinent search directories.

Please forward your completed Assessment, either as an attachment sent to

vnorton@AmericanDentalCo.com or

To fax: 312-455-9491.

Thank you for taking time to complete this Assessment. It will be helpful in preparing our analysis and recommendations for growing your Practice.