



Practice Health History

Patterson Account # _____

Practice Name: _____

Address: _____

City/Zip: _____

Office Phone: _____

Office Fax: _____

Office Email: _____

Practice Type:

GP Perio OMS Pedo Ortho Multi-Specialty

PRACTICE OWNER(S):

Name(s): _____

Email: _____

Mobile: _____

STAFF PROFILE:

Dentist owner(s): _____

Associate dentists: _____

Dental assistants: _____

Hygienists: _____

Front desk: _____

Office managers: _____

Other auxiliary team members: _____

Total staff: _____

Practice Health History (2 of 2)

OFFICE HOURS:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

PRACTICE PROFILE:

Number of new patients per month: _____

Number of active patients: _____

Number of hygiene days per week: _____

Number of operatories: Doctor _____ + Hygiene _____ = Total _____

Number of hygiene appointments scheduled for the next 6 months: _____

Year-to-date collections: _____

Last full month of collection: _____

Number empty or unused operatories? _____

Why? _____

Complete this form and return it to: ryan@stlouisdentalequipment.com. Feel free to contact us if you have any questions: 314.595.1300