



## Client Introduction Survey

Please take a few moments to complete our survey. The information that you share with us is privileged and confidential and will be used to develop an agenda for our visit.

ORTHODONTIST NAME(S)	# YEARS IN PRACTICE

CONTACT INFORMATION	
Main Office Address	
Main Office Phone	
Main Office Back Line	
Main Office Fax	
Primary Email Address	
Web site	

Please provide the email address of any doctor who would like to be sent follow-up information.

PERSONAL INFORMATION	
Name	Email Address

If you have multiple office locations, please list and describe the method by which they are connected (DSL, cable modem, T1 line, etc.) and speed of that connection (1 MG upload / 4 MG download).

PRACTICE INFORMATION				
Office	Days per Month	Distance from Main Office	Connection Type	Connection Speed
Main				
Satellite 1				
Satellite 2				
Satellite 3				

Does all staff travel with doctor(s)? If not, describe:

**Are multiple offices open at the same time in terms of seeing patients?**

**Is the main office always staffed?**

**Are satellite offices always staffed?**

ADMINISTRATIVE STAFF		
Position	Name	# Years in Practice
Office Manager		
Treatment Coordinator		
Treatment Coordinator		
Treatment Coordinator		
Scheduling Coordinator		
Scheduling Coordinator		
Scheduling Coordinator		
Scheduling Coordinator		
Insurance Coordinator		
Financial Coordinator		

**Do you use a bookkeeper or an accounting firm for the following services?**

- Bank Reconciliation            Yes  No
- Payroll                            Yes  No
- Paying Bills                    Yes  No
- Monthly Bookkeeping        Yes  No
- Tax Preparation                Yes  No

CLINICAL STAFF		
Position	Name	# Years in Practice
Clinical Coordinator		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Clinical Assistant/RDA		
Lab Technician		
Records Technician		

**TREATMENT MECHANICS**

Type of Bracket: \_\_\_\_\_

Bonding method:

- Direct
- Indirect

Do you use a digital model service?

- Yes
- No

Rotation interval (weeks) between visits: \_\_\_\_\_

## **SOFTWARE**

**Which Practice Management software (Orthotrac, Dolphin, Ortho II, Tops, etc.) do you use and what is the current version?**

**Please check the additional software packages that you are using:**

- Communications
- Electronic Charting
- Patient Flow
- Electronic Insurance Claims
- Electronic Statements
- Collections
- ACH Drafting/Credit Card Drafting
- Pearl
- Aquarium
- IACT Presentation Software
- Televox
- Sesame
- ZACC
- OrthoBanc
- Quicken/QuickBooks

## IMAGING

Which Digital Imaging system do you use and what is the current version?

Are you using digital radiography? If so, who is the manufacturer?

If you have satellite offices, to what extent do you use digital radiography in those offices?

Do you download photographs in satellite offices?

- Yes
- No

What digital camera are you using?

**Do you print letters in satellite offices?**

- Yes
- No

**Are you using 3D technology? If so, please describe:**

**Do you plan to integrate 3D technology into your practice in the next three years?**

- Yes
- No

**HARWARE / TECHNOLOGY**

Technical Engineers / Company / Individuals that support your hardware and network:

Individual or Company Name	Phone #	Are you pleased with their services?

## FINANCIAL INFORMATION

*\*Please send current fee sheet*

FEES	
Phase I	
Child Full	
Adult Full	
Invisalign	

Net production this year:	Previous year end:
Net collection this year:	Previous year end:
# of exams this year:	Previous year end:
# of starts this year:	Previous year end:
# of debands this year:	Previous year end:

**Do you accept insurance assignment?**

- Yes
- No

**Are you a PPO or HMO provider?**

- Yes
- No

**MISCELLANEOUS**

**Why did you contact impact360?**

**How did you hear about impact360?**

**Have you worked with other consultants? Are you currently working with other consultants?**

**Are you a member of a professional study club? If so, please list name of study club.**

**What are the three most challenging issues your practice faces?**

**What are your consulting goals?**

Thank you for completing our questionnaire. This detailed information will assist us in getting to know you, your practice and your goals. Once completed, please send to:

impact360  
5382 Mt. Vernon Preserve  
Murrayville, GA 30564

You can also send by fax to (770) 983-2450

You can submit the form to us via e-mail by clicking the button below.