

Tell us about your practice

Name of practice /clinic: No of clinics:

Phone/Mobile: Email:

Name of the Proprietor of Practice:

Clinic Address & Landmarks:

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No. of Chairs: Possibility to accommodate additional chairs: Yes/No How Many.....

Catering to what type of Clientele - High/Medium/Low Income group:

Commercial/Residential Property: Lease/Ownership:

Details of Furnishings & Toilets:

Total Area of Clinic (in sq ft.): No. of Footfalls Per Day:

Details of Equipment & Manufacturers:

1..... Age: Purchase Price/Depreciated Value:

2..... Age: Purchase Price/Depreciated Value:

3..... Age: Purchase Price/Depreciated Value:

Specialist Treatments Practiced (Please Tick): RCT/Implant/Ortho/Perio/Smile Designing/Oral Surgeries/Crown & Bridges

Details of Specialist Treatments(No. of Patients in last 3 months) :

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Name & Specialities of working Doctors including part-time visiting doctors:

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Details of Non-clinical Staff on payroll & salaries:

Fixed Monthly Expenditure: Monthly Revenue:

Corporate Tie-ups, if any:

Please provide latest photos of the clinic, including photos of the interior, exterior and signage