

DOCTOR'S NAME(S): \_\_\_\_\_

PHONE: OFFICE: \_\_\_\_\_ HOME: \_\_\_\_\_

FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

## GENERAL INFORMATION

SQUARE FOOTAGE: \_\_\_\_\_

NUMBER OF DOCTORS: RIGHT-HANDED \_\_\_\_\_ LEFT-HANDED \_\_\_\_\_

### TYPE OF DELIVERY SYSTEM REQUIRED:

LEFT SIDE \_\_\_\_\_ OVER PATIENT \_\_\_\_\_ REAR \_\_\_\_\_ RIGHT SIDE \_\_\_\_\_ OTHER \_\_\_\_\_

### NUMBER OF OFFICE PERSONNEL:

ORTHODONTISTS \_\_\_\_\_ SECRETARY \_\_\_\_\_ RECEPTIONIST \_\_\_\_\_

FULL-TIME CHAIR ASSISTANTS \_\_\_\_\_ PART-TIME CHAIR ASSISTANTS \_\_\_\_\_

LAB TECHS \_\_\_\_\_ STERILIZING \_\_\_\_\_ OTHER \_\_\_\_\_

### NUMBER OF CHAIRS REQUIRED:

IN BAY AREA \_\_\_\_\_ IN ADULT AREA \_\_\_\_\_ IN BONDING AREA \_\_\_\_\_ IN CONSULTATION AREA \_\_\_\_\_

IN EXAM AREA \_\_\_\_\_ IN RECORDS ROOM \_\_\_\_\_ OTHER \_\_\_\_\_

NUMBER OF CHAIRS PRESENTLY: MFG: \_\_\_\_\_

NUMBER OF UNITS PRESENTLY: MFG: \_\_\_\_\_

## EQUIPMENT INFORMATION

### OPERATORY LIGHTING:

ELEF \_\_\_\_\_ UNIT MOUNTED \_\_\_\_\_ GOOSENECK \_\_\_\_\_

CEILING \_\_\_\_\_ ALGER \_\_\_\_\_ OTHER \_\_\_\_\_

STERILIZATION: AREA \_\_\_\_\_ OR STERILIZATION ROOM \_\_\_\_\_

STERILIZER \_\_\_\_\_ OTHER \_\_\_\_\_

ULTRASONIC \_\_\_\_\_

COMPUTERS: NUMBER \_\_\_\_\_ WHERE \_\_\_\_\_

## ROOM SIZES

WAITING ROOM: NUMBER OF CHAIRS: \_\_\_\_\_

KIDS AREA: S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_

RECEPTION AREA: S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_

BUSINESS OFFICE: S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_

STORAGE ROOM: S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_

TOOTH BRUSHING AREA: NUMBER OF SINKS \_\_\_\_\_

ON DECK AREA: SEATING CAPACITY \_\_\_\_\_



FOR PLANNING ASSISTANCE, CALL  
**Joe or Bob Ross 1.800.247.4109 OR 972.775.8757**

# OFFICE LAYOUT

**CONSULTATION ROOM: SIZE:** \_\_\_\_\_  
TABLE \_\_\_\_\_ CHAIRS \_\_\_\_\_ EXAM CHAIR \_\_\_\_\_ VIEWBOX \_\_\_\_\_ SINK \_\_\_\_\_  
OTHER \_\_\_\_\_

**RECORDS ROOM:**  
PAN \_\_\_\_\_ CEPH \_\_\_\_\_ PAN-CEPH \_\_\_\_\_ CONTBEAM \_\_\_\_\_ ICAT \_\_\_\_\_  
EXAM CHAIR \_\_\_\_\_ DELIVERY UNIT \_\_\_\_\_

**LABORATORY:**  
NUMBER OF SINKS \_\_\_\_\_ WET LAB \_\_\_\_\_ DRY LAB \_\_\_\_\_  
EQUIPMENT \_\_\_\_\_

**PATIENT BATHROOM:**  
IN SUITE \_\_\_\_\_ OUTSIDE \_\_\_\_\_ # OF HANDICAP REQUIRED \_\_\_\_\_

## OTHER ROOMS

**STAFF LOUNGE:**  
SINK \_\_\_\_\_ CABINETS \_\_\_\_\_ REFRIGERATOR \_\_\_\_\_ BATHROOM \_\_\_\_\_ LOCKERS: \_\_\_\_\_

**PATIENT EDUCATION ROOM OR ALCOVE :**  
SINK \_\_\_\_\_ CABINETS \_\_\_\_\_ MIRROR \_\_\_\_\_ OTHER \_\_\_\_\_

**DOCTOR'S PRIVATE OFFICE:**  
DESK SIZE \_\_\_\_\_ # OF CHAIRS \_\_\_\_\_ BATHROOM \_\_\_\_\_ SHOWER \_\_\_\_\_  
OTHER \_\_\_\_\_

**MECH. ROOM:**  
INSIDE SUITE \_\_\_\_\_ OUTSIDE SUITE \_\_\_\_\_

**EQUIPMENT LOCATION: (IN OR OUT OF SUITE, LOCATION IN SUITE)**  
HEATING-AIR \_\_\_\_\_ WATER HEATER \_\_\_\_\_ COMPRESSOR \_\_\_\_\_ VACUUM PUMP \_\_\_\_\_  
WASHER & DRYER \_\_\_\_\_ NITROGEN \_\_\_\_\_

## MISCELLANEOUS

**PRIVATE ENTRANCE:** DOCTOR \_\_\_\_\_ STAFF \_\_\_\_\_

**ENTRANCE EACH DAY:** FRONT DOOR \_\_\_\_\_ REAR DOOR \_\_\_\_\_

**EXIT EACH DAY:** FRONT DOOR \_\_\_\_\_ REAR DOOR \_\_\_\_\_

**OTHER:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_