



**UNTHANK**  
DESIGN GROUP

**DESIGN PROGRAM**

Name: \_\_\_\_\_

Address: Office: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: Office: \_\_\_\_\_ Home: \_\_\_\_\_  
Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Is this project confidential?: \_\_\_ No \_\_\_ Yes, from? \_\_\_\_\_

Specialty: \_\_\_\_\_

Are you currently using any of the following consulting services?

	Yes	No
Management Consulting (If yes, whom?) _____	___	___
Technology Consulting	___	___
Financial Consulting	___	___
Clinical Consulting	___	___
Management Manuals & Tapes	___	___

Have you attended our Office Design seminar? \_\_\_ Yes \_\_\_ No  
Please list any others: \_\_\_\_\_

**Project Type:**

- \_\_\_ New Free-Standing Building for your practice only
- \_\_\_ New Free-Standing Building with additional office lease space
- \_\_\_ Lease Space or Condominium in:
  - \_\_\_ Existing Building or \_\_\_ Building to be Constructed
  - \_\_\_ Existing Building to be \_\_\_ Remodeled \_\_\_ & Expanded
  - \_\_\_ Existing Suite to be \_\_\_ Remodeled \_\_\_ & Expanded

Number of floors in the building? \_\_\_\_\_  
On which floor will your office be located? \_\_\_\_\_  
Doctor's estimate of New Square Footage? \_\_\_\_\_  
Number of Doctors who will work in this office? \_\_\_\_\_  
Maximum number of Doctors at any one time? \_\_\_\_\_  
Maximum number of Hygienists at any one time? \_\_\_\_\_  
Doctor's dominant hand: Right \_\_\_\_\_ Left \_\_\_\_\_

Projected staffing of the new office:

Doctors \_\_\_\_\_

Business \_\_\_\_\_

Clinical:

Hygienists \_\_\_\_\_

Assistants \_\_\_\_\_

Lab. Tech. \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

What are the major goals you wish to achieve with this new office?

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What are the reasons you have chosen **Unthank Design Group** to assist with the design of your new office?

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As background information on your project, please fill out only *one* of the following three items:

If you are:

1) *building* your own building,  
what is your land cost? \_\_\_\_\_

How many square feet of land do you have? \_\_\_\_\_

2) *buying* a condominium,  
what is the purchase cost? \_\_\_\_\_

If there is a "finish out" allowance included in the price, how much is it? \_\_\_\_\_

3) *leasing* a new space,  
what is the rental rate? \_\_\_\_\_

If there is a "common area maintenance" fee, how much is it? \_\_\_\_\_

If there is a "finish out" allowance, how much is it? \_\_\_\_\_

Are utilities included in your rent? \_\_\_\_\_

What is your budget range for *construction only* (exclusive of land, equipment, furnishings, design and other incidental costs)? \_\_\_\_\_

How much cash will you put into the project (including design, legal, accounting fees)? \_\_\_\_\_

If you have talked with your lenders and have the necessary information, please answer the following; otherwise, industry standards can be used.

What terms have you been quoted?

Interest rate \_\_\_\_\_

Points \_\_\_\_\_

Length of amortization \_\_\_\_\_

What is your current rent or building debt service (including utilities and taxes) for which you will no longer be responsible? \_\_\_\_\_

What is your current monthly production (last six months average, including hygiene production) \_\_\_\_\_

Number of Doctors (full time) \_\_\_\_\_

Number of Hygienists (full time) \_\_\_\_\_

Number of hours of chair time scheduled per week per provider \_\_\_\_\_

Total number of operatories currently being Used (including hygiene) \_\_\_\_\_

How many new patients per month are taken into your practice? (Please list for each Doctor.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is your *true* practice overhead? (without auto lease, club dues or other personal expenses included in your corporation) \_\_\_\_\_

Has your production risen \_\_\_ or dropped \_\_\_ in recent months?

How much? \_\_\_\_\_

If either, to what do you attribute the change?

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**Reception/Waiting Area:**

Would you like an entry "Vestibule" (an "airlock", two sets of entry doors)? \_\_\_\_

Number of adult seats needed: \_\_\_\_\_

Do you want a children's area? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe: \_\_\_\_\_

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Would you like a coffee/juice bar? Yes \_\_\_\_ No \_\_\_\_

Would you like an area for patient coats? Yes \_\_\_\_ No \_\_\_\_

If yes, on hangers \_\_\_\_ hooks \_\_\_\_ or our discretion \_\_\_\_

Would you like a door separating the Waiting Area from the rest of the office?

Yes \_\_\_\_ No \_\_\_\_

Please describe anything else you would like in the Waiting Area (e.g., TV, antiques, bulletin boards, etc.): \_\_\_\_\_

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**Business Area:**

Number of employees anticipated:

Full-time \_\_\_\_\_

Part-time \_\_\_\_\_

Please list each employee and their major responsibilities, e.g.:

Receptionist – greeting, appointing, receive payment, answer telephone

Business Assistant – financial arrangements, insurance, A/R, A/P)

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**Consultation & Financial Arrangements:**

Would you like a semi-private Financial Arrangements Area near the Reappointing Area? Yes \_\_\_\_ No \_\_\_\_

Where will you make case presentations?

Chair Side \_\_\_\_ Consult Room \_\_\_\_

Who will usually be present? \_\_\_\_\_

**Business Equipment:**

Files:

If currently using paper charts, how many folders do you need to provide for?

Active \_\_\_\_\_ Inactive \_\_\_\_\_

How many inactives do you want in your office as opposed to remote storage? \_\_\_\_\_

Do you have any file cabinets that you wish to re-use? Yes \_\_\_ No \_\_\_  
(If yes, please provide dimensions with either photographs or sketches.)

If buying new, do you have a preference as to type as opposed to leaving it to our discretion? Yes \_\_\_ No \_\_\_

If yes, Lateral \_\_\_\_\_  
Revolving Lateral \_\_\_\_\_  
Slant Lateral \_\_\_\_\_  
Sliding Lateral \_\_\_\_\_  
Built-in Lateral \_\_\_\_\_  
(Other) \_\_\_\_\_

Do you plan to move toward a "paperless" office? Yes \_\_\_ No \_\_\_

Computer:

Do you currently have computers in your operatories? Yes \_\_\_ No \_\_\_

Do you plan to integrate computers in your operatories? Yes \_\_\_ No \_\_\_

Where will you want terminals located? \_\_\_\_\_

Where do you want printers located? \_\_\_\_\_

What dental software program(s) will you incorporate? \_\_\_\_\_

\_\_\_\_\_

Copy Machine:

Floor-standing \_\_\_\_\_ or countertop type \_\_\_\_\_

Overall Dimensions \_\_\_" h x \_\_\_" w x \_\_\_" d

What is the overall height with the top open? \_\_\_\_\_

Miscellaneous Business Machines:

\_\_\_\_\_

**Treatment Area:**

Number of operatories needed \_\_\_\_\_

Will all operatories be designed and equipped identically? Yes \_\_\_ No \_\_\_

If not, explain the differences: \_\_\_\_\_

Will you have a "Clinical Workstation" computer terminal in each treatment room for use by the Staff? Yes \_\_\_ No \_\_\_

A "multimedia monitor" for use by the patient (e.g.: Intra-Oral Video, Patient Education, entertainment, etc.)? Yes \_\_\_ No \_\_\_

Type of Delivery System Desired:

Flexible rear delivery: Cart \_\_\_ or Arm \_\_\_

Chair delivery: Over The Patient \_\_\_ or Doctor's Side Delivery \_\_\_

Side Delivery from the Doctor's side wall or cabinet \_\_\_

Will you use any Dental Equipment Manufacturer Operatory Cabinetry?

If yes, please provide specifics: \_\_\_\_\_

What type of operatory dental light will be used?

Ceiling mounted track \_\_\_\_\_ Brand \_\_\_\_\_

Ceiling mounted post \_\_\_\_\_ Brand \_\_\_\_\_

Chair mounted \_\_\_\_\_ Brand \_\_\_\_\_

Wall mounted \_\_\_\_\_ Brand \_\_\_\_\_

Where will the following treatment technologies be used?

Item, Where & How	Drs.	Hyg.	Cart or	Permanently Installed (Docking Station?)
Intra-Oral video	___	___	___	___
Digital Radiography	___	___	___	___
Digital Photography	___	___	___	___
Cavitron(s)	___	___	___	___
Cavijet(s)	___	___	___	___
Light-cure unit(s)	___	___	___	___
Air Abrasion	___	___	___	___
Laser(s)	___	___	___	___

How many Treatment Rooms will have P.A. X-Ray machines? \_\_\_\_\_

Existing # \_\_\_\_\_ Model \_\_\_\_\_

New # \_\_\_\_\_ Model \_\_\_\_\_

If incorporating Digital Radiography, will you be using sensors, a scanner or both? \_\_\_\_\_

**Treatment Area:** cont'd

Will you use any patient monitoring equipment for anesthesia procedures? Yes \_\_\_ No \_\_\_

If yes, please elaborate \_\_\_\_\_

Would you like a "Recovery Room" for post-surgery patients? Yes \_\_\_ No \_\_\_

Would you like a "Surgery Exit", not passing through the Waiting Area? Yes \_\_\_ No \_\_\_

**"Technology Alcove":**

Would you like a centrally located "alcove" that could be used for the various technologies related to the Treatment Area, such as printer(s) (networked Intra-Oral Video printer, inkjet, laser), computer terminal, DVD, etc.? Yes \_\_\_ No \_\_\_

Would you like an area for the storage of cart delivered technologies to be used in the Treatment Rooms? Yes \_\_\_ No \_\_\_

Do you have any mobile devices requiring a place to "park" when not in use? Yes \_\_\_ No \_\_\_; If yes, please elaborate (e.g.: Cerec, Biolase, etc.): \_\_\_\_\_

**Product Display Area:**

Would you like to display / dispense recommended products? Yes \_\_\_ No \_\_\_

**Sterilization Area:**

Anticipated daily average hygiene appointments \_\_\_\_\_

Anticipated daily average treatment appointments \_\_\_\_\_

What percentage of your practice will be ortho? \_\_\_\_\_

What sterilizer type(s) will be used? \_\_\_\_\_

Will your sterilizer(s) require connections to water and sewer? Yes \_\_\_ No \_\_\_

Required voltage \_\_\_\_\_ v

Brand(s) & model(s) \_\_\_\_\_

Dimensions \_\_\_ wide x \_\_\_ high x \_\_\_ deep

Dimensions \_\_\_ wide x \_\_\_ high x \_\_\_ deep

Will you be using Hydrocolloid? Yes \_\_\_ No \_\_\_

**Pre-Set Concept:**

Cassettes & Tubs \_\_\_ (recessed ultrasonic recommended)

Wraps & Tubs \_\_\_

Trays & Tubs \_\_\_

Will you be using a dishwasher for drying cassettes &/or disinfection? Yes \_\_\_ No \_\_\_



**Lab:**

What type of lab would you like?

Pour-Up \_\_\_\_ Production \_\_\_\_

If full production, indicate the square footage desired: \_\_\_\_\_

If a "pour-up" lab is desired, we will provide for compressed air, lab vacuum, plaster bins or drawers, a sink and counter space for pour-up and the following:

Model trimmer \_\_\_\_\_  
Lathe \_\_\_\_\_  
Vacuum forming machine \_\_\_\_\_  
Gas outlet(s) \_\_\_\_\_ How many? \_\_\_\_  
Porcelain Glazing Oven \_\_\_\_\_  
Knee Space(s) \_\_\_\_\_ How many? \_\_\_\_  
Case Pans \_\_\_\_\_ How many? \_\_\_\_  
Porcelain Milling Device \_\_\_\_\_  
(Other) \_\_\_\_\_

Radiography:

Will you have a panoramic X-ray machine? Yes \_\_\_ No \_\_\_  
With a cephalometric attachment? Yes \_\_\_ No \_\_\_  
Will you use wall mounted cephalometric brackets? Yes \_\_\_ No \_\_\_  
  
Would you like a Central Periapical X-ray area? Yes \_\_\_ No \_\_\_  
Will this be used with cephalometric brackets? Yes \_\_\_ No \_\_\_

Film Processing:

Will you incorporate digital radiography?  
Using sensors? Yes \_\_\_ No \_\_\_ Mfgr. \_\_\_\_\_  
Using a scanning system? Yes \_\_\_ No \_\_\_ Mfgr. \_\_\_\_\_

Do you want a darkroom? Yes \_\_\_ No \_\_\_  
If yes, with a large format processor? Yes \_\_\_ No \_\_\_  
Deep sink \_\_\_\_ Duplicator \_\_\_\_ Developing tank \_\_\_\_  
Other \_\_\_\_\_

Will you use a daylight-loaded processor? Yes \_\_\_ No \_\_\_  
Brand & Model \_\_\_\_\_

What percentage of your films will be processed by:  
Hygienists \_\_\_\_\_ Assistants \_\_\_\_\_

**Doctor's Office(s):**

How many offices do you want? \_\_\_\_

Do you have a room size preference? \_\_\_\_

Our discretion? \_\_\_\_

What type of desk do you want? \_\_\_\_\_

Built-in \_\_\_\_ dim. \_\_\_\_" x \_\_\_\_"

- or -

Free-standing:

Against wall \_\_\_\_ dim. \_\_\_\_" x \_\_\_\_"

- or -

Center of room \_\_\_\_ dim. \_\_\_\_" \_\_\_\_"

Additional furniture:

If existing to be reused:

Credenza? Yes \_\_\_ No \_\_\_ dim. \_\_\_\_" x \_\_\_\_"

Side Return? Yes \_\_\_ No \_\_\_ dim. \_\_\_\_" x \_\_\_\_"

Comp. Term.? Yes \_\_\_ No \_\_\_ dim. \_\_\_\_" x \_\_\_\_"

Bookshelves? Yes \_\_\_ No \_\_\_ dim. \_\_\_\_" x \_\_\_\_"

Do you need any other seating in this room? Yes \_\_\_ No \_\_\_

If yes, please describe and give dimensions of any existing furniture to be reused.

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Do you want a private restroom? Yes \_\_\_ No \_\_\_

Do you want a private shower? Yes \_\_\_ No \_\_\_

Do you want a private closet? Yes \_\_\_ No \_\_\_

**Staff Lounge:**

Total number attending office team meetings: \_\_\_\_\_

Would you like a Staff Lounge? Yes \_\_\_ No \_\_\_

If yes, describe the furniture you would like (e.g., rectangular table and five chairs):

\_\_\_\_\_

Is this space to double as a "conference facility" (teaching, etc.)? Yes \_\_\_ No \_\_\_

Please elaborate \_\_\_\_\_

Would you like a Kitchenette (typically 6' of counter with a sink)? Yes \_\_\_ No \_\_\_

Please indicate what you would like to include:

Microwave: Yes \_\_\_ No \_\_\_

Dishwasher: Yes \_\_\_ No \_\_\_

Disposal: Yes \_\_\_ No \_\_\_

Ice Maker: Yes \_\_\_ No \_\_\_

Refrigerator: Under-counter \_\_\_ - or - Full Sized \_\_\_

Coat closet and cubicle lockers? \_\_\_ - or - Full Lockers \_\_\_

Staff restroom Yes \_\_\_ No \_\_\_

Clinical Attire storage Yes \_\_\_ No \_\_\_

Washer/Dryer? Yes \_\_\_ No \_\_\_

Stacking \_\_\_ - or - side by side \_\_\_

A Changing Area in addition to the Clinical Attire Space and Staff restroom?

Yes \_\_\_ No \_\_\_

Would you like a "UPS Receiving Area"? (a strong shelving unit to prevent boxes from being scattered in the Staff Lounge) Yes \_\_\_ No \_\_\_

**Storage:**

Supply Storage:

We will provide Supply Storage based on your office parameters (e.g.: # of patients per day) unless directed otherwise.

Would you like a Bulk Storage room (e.g., for seasonal decorations)? Yes \_\_\_ No \_\_\_

Unless otherwise indicated, we will provide for Business Supply storage in the Business Area cabinetry.

**Mechanical Equipment:**

Where will the "furnaces" (air handling units) be located?

Above the ceiling as a "horizontal package" Yes \_\_\_ No \_\_\_  
or in a "furnace room"? Yes \_\_\_ No \_\_\_

**Dental Mechanical Equipment:**

Will you have your own compressor and vacuum? Yes \_\_\_ No \_\_\_

Will this equipment be located in your space? Yes \_\_\_ No \_\_\_

Will you have an amalgam separator? Yes \_\_\_ No \_\_\_

**Medical Gases:**

Will you use a mobile nitrous cart? Yes \_\_\_ No \_\_\_

Will nitrous be plumbed to each treatment chair? Yes \_\_\_ No \_\_\_

Number of tanks to be stored: \_\_\_\_

**Janitorial Supply Closet:**

For general cleaning supplies. Would you like one? Yes \_\_\_ No \_\_\_

Combined with Furnace Room? Yes \_\_\_ No \_\_\_

**Handicapped Accessible Restroom Requirements:**

Generally, current interpretations of the Americans with Disabilities Act (a Federal Law) require *all* to be "accessible". Individual States have adopted additional regulations. The more strict regulations govern.

Along with the Staff and Doctor's restrooms (as listed previously) we will provide one unisex restroom for patients, unless otherwise directed:

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