How Dental Practices Are Valued in 2026: A Framework for Practice Owners

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Executive Summary

Dental practices in 2026 are valued using three primary methods: percentage of collections (65 to 85 percent of annual gross for general practices in private sales), seller's discretionary earnings multiple (1.75x to 2.25x for private buyers), and EBITDA multiple (5x to 11x or higher, depending on practice scale and buyer type). The method that applies to a given practice is not a matter of preference; it is determined by two structural variables: practice size and buyer type. This report introduces the **PPR Multiple-Decoder Framework**, a four-quadrant decision matrix that tells a practice owner which valuation lens applies to their specific situation, what the numeric range looks like in that quadrant, and what the multiple does not capture about deal economics. The framework is built from a synthesis of twelve named broker and industry sources active in the 2026 dental transaction market.

1. The PPR Multiple-Decoder Framework

The most common error in dental practice valuation is applying the wrong method to the wrong quadrant. A solo general practice owner reading about 9x EBITDA multiples on dental industry podcasts, then expecting that multiple to apply to their own private-buyer sale, is a recipe for a permanent misread of the market.

Two structural variables determine which multiple applies: **practice size** (measured by EBITDA, since that is the variable buyers actually price on) and **buyer type** (private individual buyer versus institutional buyer). These two variables produce a four-quadrant grid:

	Private buyer	Institutional buyer (DSO / IDSO / PE)
Sub-$1M EBITDA (typical solo practice)	**Quadrant 1**: collections multiple is the dominant lens. Range: 65 to 85 percent of annual gross collections. SDE multiple as cross-check at 1.75x to 2.25x. EBITDA multiple, if computed, lands at 4x to 6x.	**Quadrant 2**: small DSO add-on. EBITDA multiple is the lens. Range: 5x to 7x EBITDA. Practices in this quadrant must clear the institutional-buyer qualification floor (collections above $1M, multiple operatories, transferable patient base) or the buyer pool drops back to Quadrant 1.
$1M+ EBITDA (mid-sized group, multi-doctor, or premium solo)	**Quadrant 3**: rare. Most $1M+ EBITDA practices price institutionally because the private-buyer pool that can finance acquisition at this scale is thin. Practices that do transact privately in this quadrant typically use SDE or EBITDA multiples in the 6x to 8x range.	**Quadrant 4**: institutional acquisition. EBITDA multiple is the lens. Range: 7x to 9x for $1M to $3M EBITDA, 9x to 11x for $3M to $5M, and 11x or higher for $5M+ EBITDA platform-level acquisitions to private equity buyers.

Buyer quadrant drives a 4x valuation swing. A 2x2 matrix mapping practice EBITDA tier and buyer type to the dominant valuation method and numeric range for each quadrant.

The same practice can sit in different quadrants for different prospective buyers. A $1.2M-collection solo practice might price at 70 percent of collections to a retiring colleague's daughter buying her first practice ($840K), and at 6x EBITDA on a $300K EBITDA base to a regional DSO ($1.8M). The 40 to 80 percent DSO premium tracks the quadrant shift; the underlying operation has not changed.

This framework is the spine of the rest of this report. Every numeric range, every adjustment factor, and every deal-structure caveat ties back to which quadrant the practice operates in.

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2. Valuation Method 1: Percentage of Collections

The percentage-of-collections method is the most common shorthand for valuing dental practices in private (non-DSO) transactions. General practices currently trade at **65 to 85 percent of annual gross collections** in 2026. For a practice collecting $1 million annually, this yields a valuation range of $650,000 to $850,000.

The method's appeal is simplicity. Collections are the most reliably reported financial figure in dentistry; ADA Health Policy Institute survey data places average general dentist gross billings at

$942,290 per year (2024 data). A multiplier applied to that number produces a defensible price band quickly, which is why brokers, lenders, and CPAs all reach for it first.

The method's structural weakness is that two practices collecting the same amount can be worth materially different amounts. A practice collecting $1M with 60 percent overhead clears $400K in operating profit; a practice collecting $1M with 75 percent overhead clears $250K. Applying the same 75 percent of collections multiplier to both produces the same valuation ($750K) on businesses with very different underlying economics. This is why the percentage-of-collections method is increasingly used as a sanity check rather than a primary valuation tool, and why sophisticated buyers cross-reference it against SDE or EBITDA every time.

The 65 to 85 percent range itself is wider than it looks. The bottom of the range applies to practices with high overhead, owner-dependent production, deferred technology, declining collections trend, or rural location with thin buyer pools. The top of the range applies to practices with associate-driven production, modern digital workflow, growing patient base, and metropolitan location. *Where in the range a specific practice lands is determined by the adjustment factors documented in Section 5*, not by negotiation skill.

Sources: FOCUS Investment Banking, "Dental Practice Valuation" (2026); ADA Health Policy Institute, 2024 economic-survey data; Peak Business Valuation, dental practice multiples reference (2025-2026).

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3. Valuation Method 2: Seller's Discretionary Earnings (SDE) Multiple

The SDE multiple method prices the practice on cash flow available to a single owner-operator, not on top-line revenue. SDE equals net income plus owner compensation, owner discretionary expenses, non-recurring items, and depreciation. For a practice with $350,000 in SDE, private buyers in 2026 typically pay **1.75x to 2.25x SDE**, yielding $612,500 to $787,500.

The SDE method matters because it answers the question a private buyer actually asks at the closing table: how much cash will this practice put in my pocket annually after I become the operator? Collections-based valuation does not answer that question; SDE-based valuation does.

SDE applies almost exclusively in Quadrant 1 of the framework: sub-$1M EBITDA practices acquired by private buyers. The reason is structural. A buyer who plans to own and operate one practice computes their compensation, their discretionary expenses, and their depreciation as a single combined cash-flow stream. An institutional buyer running a multi-location platform separates owner compensation (which becomes an operating expense paid to a hired clinician) from EBITDA (which becomes the metric the institutional buyer prices on). SDE collapses categories that institutional buyers separate; that is why SDE multiples appear in private-buyer transactions and EBITDA multiples appear in institutional ones.

The SDE multiple range of 1.75x to 2.25x is narrower than it looks because the SDE figure itself absorbs much of the variation. A practice with strong fundamentals and clean books produces a higher SDE than a practice with the same collections but dirtier financials, and the multiplier then applies to that already-higher SDE base. Two practices with the same collections and the same nominal multiplier can transact at different absolute prices because their SDE bases differ.

Sources: Peak Business Valuation, dental SDE multiples (2025-2026); FOCUS Investment Banking, "Dental Practice Valuation" (2026); ADCPA practice-economics benchmarks (2025).

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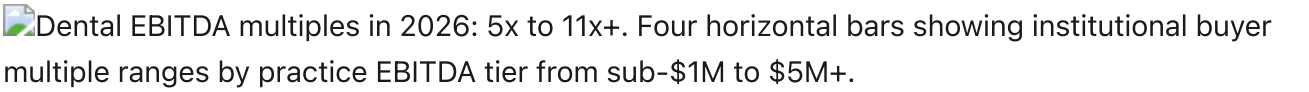
4. Valuation Method 3: EBITDA Multiple

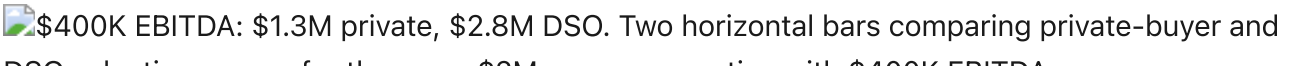
The EBITDA multiple method is the dominant valuation lens in institutional (DSO, IDSO, private equity) dental practice transactions. EBITDA equals earnings before interest, taxes, depreciation, and amortization, with normalizing adjustments to remove owner compensation and discretionary expenses. The 2026 multiple range is wider and more stratified than the other two methods, and it is the one that gets the most attention in industry press and on broker podcasts.

The 2026 EBITDA-multiple stratification:

Practice EBITDA	Typical Multiple Range	Buyer Profile
Under $1 million	5x to 7x	Independent buyer or small DSO
$1 million to $3 million	7x to 9x	Regional DSO add-on
$3 million to $5 million	9x to 11x	Emerging platform or strategic acquirer
$5 million or higher	11x or higher (select cases)	Platform-level private equity buyer



Take a $2 million revenue practice running 20 percent EBITDA margins ($400,000 EBITDA). To a DSO buyer at 6x to 7x, the practice transacts at $2.4 million to $2.8 million. To a private buyer at 65 to 85 percent of collections, the same practice transacts at $1.3 million to $1.7 million. The same operation, two valuation lenses, a 40 to 80 percent gap. This is the DSO premium that defines the two-tier 2026 dental transaction market.

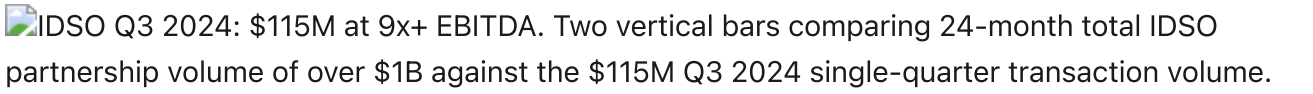


The premium is genuine, but seller cash-at-close almost always trails it. Institutional offers at the high end of the multiple range almost always carry deal structure that shrinks what the seller actually walks away with relative to the offer price: rollover equity (the seller takes a portion of

consideration as DSO equity rather than cash, exposing them to the DSO's eventual recap outcome), earnouts contingent on post-close performance, employment terms requiring the seller to remain clinical for three to five years, and tax-treatment trade-offs. The PPR Premium-vs-Pocket Framework, documented in a forthcoming companion brief, decomposes the offer-to-cash math on institutional sales.

The stratification by EBITDA tier reflects how DSO and PE buyers actually price. A DSO add-on under $1M EBITDA contributes incrementally to the platform; multiples reflect that. A platform-level acquisition at $5M+ EBITDA represents a strategic foothold in a region or segment, and the buyer pool narrows to a small number of well-capitalized PE platforms competing aggressively for it. The 11x-plus multiples at the top of the stratification come from that competitive dynamic; the methodology is the same one used at lower tiers.

Sources: FOCUS Investment Banking, "Dental Practice Valuation" (2026); TUSK Practice Sales, 2025 Market Review and 2026 Outlook; Q2 2026 Dental Market Report; Large Practice Sales (Chip Fichtner) podcast appearances (2025), reporting over $1 billion of IDSO partnerships completed in the prior 24 months including Q3 2024 alone with $115 million at over 9x EBITDA.



5. The Multiple-Decoder Framework Applied: One Case Per Quadrant

The framework's value comes from showing what valuation actually looks like for a specific practice. Four cases illustrate the spread, one per quadrant.

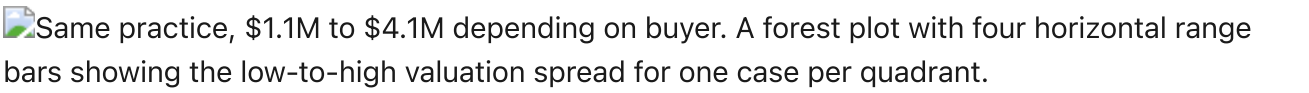
Quadrant 1: Solo GP collecting $850,000, owner produces 80 percent of clinical revenue, 70 percent overhead, suburban location, 1995 building with deferred equipment investment. Collections-multiple lens: 70 to 75 percent of $850K = $595K to $638K. SDE cross-check: SDE is approximately $200K, multiple of 1.75x to 2.0x = $350K to $400K. (The SDE cross-check at the bottom of the range signals that the collections multiple is overshooting; the deferred-equipment and owner-dependence factors compress the actual value toward the SDE-derived figure.) Private-buyer transaction range: $400K to $600K. EBITDA-based offer from a DSO would price the practice well under that range and would likely not meet the institutional qualification floor.

Quadrant 2: Solo GP collecting $1.4 million, owner produces 55 percent (associate produces the remainder), 58 percent overhead, metropolitan location, modern digital workflow. This practice qualifies for institutional buyers. EBITDA is approximately $588K (after normalizing $200K of owner compensation back into the operating expense line). At 6x to 7x = $3.5M to $4.1M from a small DSO add-on buyer. Collections-based cross-check at 80 percent = $1.12M,

well below the institutional figure; the gap is the DSO premium. Private-buyer alternative would price closer to the collections-based figure because the SDE base for a private buyer (computed differently, since the buyer absorbs owner compensation) is approximately $400K and 1.75x to 2.0x = $700K to $800K. Decision space: same practice, $1.1M to $4.1M depending on buyer type.

Quadrant 3: Mid-sized group with three doctors collecting $4.2 million, owner produces 35 percent (associates produce the rest), 60 percent overhead, multiple locations of operation, transitioning to second-generation owner. EBITDA approximately $1.7M. The buyer pool here is unusual: too large for most private buyers to finance comfortably, smaller than most platform-level PE acquisitions are interested in, but well within reach of regional DSOs and emerging platforms. EBITDA multiple in the 7x to 9x range applies, yielding $11.9M to $15.3M institutional valuation. A private-buyer alternative does exist (other multi-doctor groups occasionally roll up), typically in the 5x to 7x range or $8.5M to $11.9M.

Quadrant 4: Multi-location group with twelve doctors across five locations collecting $11 million, EBITDA $3.3 million, sophisticated central-management infrastructure, growing patient base. Platform-level acquisition territory. Multiple of 9x to 11x = $29.7M to $36.3M. The competitive dynamics in this quadrant are different: sale processes are run as marketed auctions with multiple PE platforms bidding, and the 50 percent above-unsolicited premium documented by TUSK Practice Sales applies most strongly here.



A forest plot with four horizontal range bars showing the low-to-high valuation spread for one case per quadrant.

Three observations from the four examples:

1. **The same practice does not have a single value.** The Quadrant 2 example has a 4x range from low-private-buyer to high-DSO outcome ($1.1M to $4.1M). Practice owners who do not understand which quadrant they qualify for routinely accept low-quadrant offers when high-quadrant offers were available.
2. **Institutional qualification is the structural pivot.** The line between Quadrant 1 (private-buyer-only) and Quadrant 2 (institutional-eligible) is the most consequential qualification a practice owner can prepare for, because it can multiply the valuation outcome by 2x to 4x.
3. **Deal structure shrinks the offer price.** The Quadrant 4 example's $36M valuation is gross consideration at a peak multiple. After rollover, earnout, employment lock, and tax treatment, the seller's cash-at-close may be a fraction of that, paid out over a 5-to-7-year horizon. The offer price is real; the offer-to-cash math determines whether the advertised number translates to what the seller walks away with.

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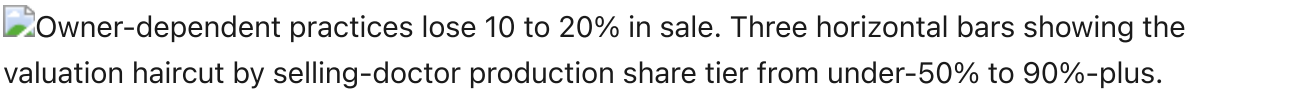
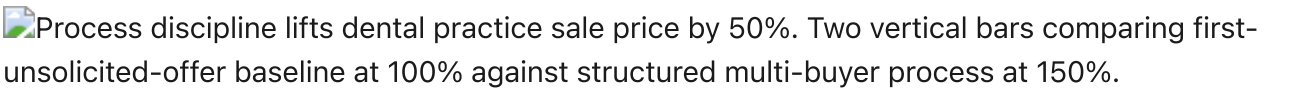
6. What These Multiples Don't Capture

The three valuation methods produce defensible price ranges. They do not capture every variable that determines the actual outcome of a practice sale. Five categories of factor sit outside the multiples and routinely determine whether a sale closes at the top or the bottom of the applicable range.

Owner-dependence and replaceability. Practices where the selling doctor produces 90 percent or more of clinical revenue see 10 to 20 percent valuation haircuts independent of the multiple methodology applied. This was the most repeated theme across every broker source surveyed for this report (FOCUS Investment Banking 2026; TUSK; The Dentalpreneur Podcast Episode 2452 with Kyle Francis of PTS, February 2026; Very Dental Podcast with Jack Minahan of Henry Schein Practice Transitions, March 2026; DDSmatch 2026 Seller's Playbook). A forthcoming companion brief introduces the PPR Replaceability Score, a five-factor self-assessment framework.



Process discipline. Practices taken to market through a structured multiple-buyer solicitation process receive final sale values averaging 50 percent above initial unsolicited offers (TUSK Practice Sales 2025 Market Review). The 50 percent gap is not better negotiation; it reflects the four structural mechanics of competitive bidding documented in the PPR Process-Premium Decomposition (forthcoming companion brief). Practice owners who respond to the first DSO call without running a process systematically lose that gap.

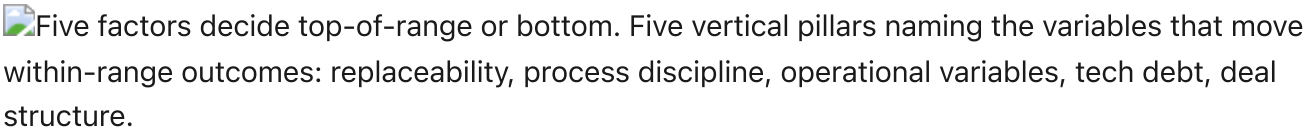


Operational variables that do not show on the financial statements. Hygienist production share, payer mix, patient retention rate, staff tenure, fee schedule competitiveness, and physical-plant condition all move the multiple within the applicable range. Practices with hygienists producing 25 to 33 percent of total revenue, retention above 85 percent, and a diversified payer mix command top-of-range multiples; practices with the inverse profile compress to bottom-of-range.

Deferred capital investment. DDSmatch's 2026 Seller's Playbook formalized the concept of "Tech Debt" in dental practice transitions: the cost a buyer must incur post-close to modernize an analog practice. Tech Debt directly reduces the sale price because the buyer pool narrows (fewer doctors want to inherit an outdated setup) and competitive bidding decreases. Conversely, practices with current digital workflow attract wider bidding and achieve higher percentages of collections.

Deal-structure trade-offs in institutional sales. Institutional offers with rollover equity, earnouts, and employment locks carry offer multiples that overstate cash-at-close. The seller's actual proceeds depend on rollover-equity outcomes (which depend on the DSO's eventual recap), earnout achievement (which depends on post-close production trajectory), and the tax-treatment delta between asset and stock-purchase structures. The offer multiple is real; the offer-to-cash math is also real.

The five categories above are not exhaustive. They are the ones that, across the broker sources surveyed for this report, most consistently determine whether a practice sells at the top, middle, or bottom of its applicable multiple range. Practice owners preparing for a sale decision benefit more from understanding these factors than from memorizing additional multiple data points.



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7. Methodology and Data Sources

This report applies the standing institutional methodology of Private Practice Research, documented at https://privatepracticeresearch.org/methodology. Key disciplines:

- Every numeric claim cites the underlying primary source within the same paragraph or table.
- Triangulation across at least two independent source classes (federal/professional-association data, industry transaction aggregates, named broker commentary) for every central finding.
- Self-reported listing data is adjusted using the haircut factor disclosed in the PPR Baseline Report Section 8.2.
- Conflicts of interest disclosure: Private Practice Research holds zero commercial relationships with dental brokers, dental service organizations, transition-advisory firms, or industry consultants whose business outcomes depend on the publications studied.

Sources for this report include FOCUS Investment Banking (2026 dental practice valuation reports), TUSK Practice Sales (2025 Market Review, Q2 2026 Dental Market Report), Peak Business Valuation (dental SDE and collections multiples reference), ADA Health Policy Institute (2024 economic-survey data, 2025 U.S. Dentist Workforce Update), ADCPA (practice-economics benchmarks 2025), Large Practice Sales podcast appearances (Chip Fichtner, 2025), The Dentalpreneur Podcast Episode 2452 (Kyle Francis, PTS, February 2026), Very Dental Podcast (Jack Minahan, HSPT, March 2026), DDSmatch 2026 Seller's Playbook, The Dentist Money Show Episode 585 (Brannon Moncrief, McLerran & Associates, 2025), and the PPR 2026 Baseline Report (PPR-BASELINE-2026-V1).

Limitations: dental practice sale prices are not systematically reported in any centralized transaction database. Transaction data cited reflects broker-published summaries and market reports, not comprehensive transaction records. Self-reported listing data carries upward bias and is adjusted accordingly. Regional granularity in publicly available data is limited; national averages mask significant variation. ADA survey data typically reflects conditions 12 to 18 months prior to publication.

Frequently asked questions

Which valuation method should a dental practice owner trust? No single method should be trusted in isolation. The PPR Multiple-Decoder Framework determines which method applies primarily based on quadrant (practice size and buyer type). Owners benefit from seeing all three numbers (collections multiple, SDE multiple, EBITDA multiple) and understanding why they differ before entering any negotiation.

What is the typical range of dental practice EBITDA multiples in 2026? EBITDA multiples in 2026 range from 5x to 7x for sub-$1M EBITDA practices acquired by independent buyers or small DSOs, 7x to 9x for $1M to $3M EBITDA practices acquired as regional DSO add-ons, 9x to 11x for $3M to $5M EBITDA emerging-platform acquisitions, and 11x or higher for $5M-plus EBITDA platform-level private equity acquisitions. The stratification reflects how institutional buyers actually price and is not affected by negotiation in the absence of structural change to the practice.

Why is there such a large gap between DSO and private-buyer valuations on the same practice? The 40 to 80 percent DSO premium reflects a structural difference in buyer economics, not a difference in the underlying practice. DSOs price on EBITDA at 6x to 12x because they value scale, associate-driven production, and platform-level operational systems. Private buyers price on collections at 65 to 85 percent because the buyer pool consists primarily of solo or small-group dentists who carry the financing as individual borrowers rather than through institutional capital structures. The same practice can sit in different quadrants for different prospective buyers; the offer-price DSO premium is real but is partially offset by deal-structure compression on institutional sales.

Does the highest-multiple offer always produce the most cash for the seller? No. Institutional offers at the high end of the multiple range almost always carry deal structure (rollover equity, earnouts, employment terms, tax-treatment trade-offs) that shrinks the seller's effective cash-at-close relative to the offer price. What the seller actually walks away with depends on the offer multiple AND the deal structure together. Practice owners benefit from running the offer-to-cash math on each offer rather than selecting based on offer multiple alone.

This report is for informational purposes only and does not constitute a practice appraisal, financial advice, or recommendation to buy or sell. Individual practice valuations depend on specific circumstances not captured in aggregate benchmarks. **PPR** | CERTIFIED +

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