

PURCHASER/ASSOCIATE QUESTIONNAIRE

Name: _____ DDS or DMD (Circle one)

Spouse/Significant Other: _____ Home: _____

Mailing Address: _____ Cell: _____

_____ Work: _____

Private E-Mail: _____ Pager: _____

Prefer to be contacted (Circle one) Home Cell Work Fax: _____

Present Status: _____ Date Available: _____

Student Dental School: _____ Graduation Year: _____

Resident Place: _____ End Date: _____

Military Division: _____ Release Date: _____

Associate Years in Practice: _____ Covenant Terms: _____

Own Yrs. in Practice: _____ Are you looking confidentially?
Y/N _____

Website: _____

If already graduated, School: _____ Graduation Year: _____

Specialty Training (if none, leave blank) _____

Specialty School _____ Graduation Year: _____

States licensed in: _____ Second Language(s): _____

Right Handed Left Handed

Experience: Cerec E4D IV Sedation Ortho TMD/TMJ IMPLANTS Endo Pedo Perio Oral Surgery

Preferably, what type of treatment would you refer out: _____

Preferred Location (check all that apply) _____

- Phoenix Metro
- West Valley
- Scottsdale/North Phoenix
- East Valley
- Flagstaff/Sedona/Prescott Area
- Tucson
- Other: _____

Which would you prefer (Check all that apply)?

- Solo
- Associate Only
- Partnership
- Associate Buy-Out
- Expand Practice

Desired Size of Practice # Ops _____ Desired Annual Gross Receipts: \$ _____

BUILDING PREFERENCE (Check One):

- Own
- Lease
- No Pref.

FINANCIAL INFORMATION

Current balance of student loans (or estimate) _____

How much money (salary + practice net profit) do you need to make per year? _____

Do you have any credit problems that might affect your ability to borrow money for the acquisition of a practice (low credit score, late or missed payments, etc)?

YES

NO

If YES, please explain

Have any disciplinary actions been filed against you by any state licensing authority (e.g.; Board of Dentistry)? (required)

- Yes
- No

Referred By: _____

(Electronically Signed)

(Date)

Curriculum Vitae/Resume Attached (if available)

CONFIDENTIALITY AGREEMENT

Potential Purchaser (“Purchaser”):

Name: _____

Address: _____

Phone: (_____) _____

Consani Seims Ltd. (“Broker”) permits Purchaser to have access to Broker’s clients (“Seller’s”) patient files, tax returns, appointment books, accounting/office records, personnel files, financial data, operating data, and other information necessary to understand Seller’s practice (“Seller’s Confidential Information”) so that Purchaser may conduct a due diligence investigation. Visits to the Seller’s office are made by pre-arranged appointment only.

Purchaser may permit Seller, at Purchaser’s option, to have access to Purchaser’s tax returns and other financial information (“Purchaser’s Confidential Information”), to permit Seller to conduct a due diligence investigation with respect to Purchaser’s credit.

Nothing in this agreement requires either party to furnish any information. However the parties expressly agree that any Seller’s Confidential Information or Purchaser’s Confidential Information (together “Confidential Information”) which is furnished or otherwise obtained is confidential. Buyer agrees to share the information with professional advisors and spouse only, and agrees to respect the fact that Seller’s desire that the fact that their practice is for sale – be kept confidential from the Seller’s staff and patients and the dental community at large.

The parties will hold Confidential Information confidential, and will not disclose it to any person other than their attorneys, brokers, and accountants. Careless or neglectful handling of this information or material could result in liability for all parties involved.

Purchaser: _____ Date: _____



16300 Christensen Rd. #213
Seattle, WA 98188
866.348.3800 Office
866.348.3809 Fax

HIPAA BUSINESS ASSOCIATE AGREEMENT

I agree to maintain the privacy protections and restrict the use and disclosure of all patient information (verbal, written or electronic) obtained from this dental office only for the purposes of serving this dental office.

I understand that I may not sell, barter, give away or reveal any patient information for personal or business gain or any form of marketing or fund raising.

I will contract with any subcontractors to whom I pass this information to hold all patient information confidential and further disclose it only for the purpose for which it was disclosed to them in the service of this dental office.

I will keep current with the industry standards for security, implement and maintain appropriate safeguards to protect this information and document all disclosures of this information with name, address and reason disclosed.

I will contact this dental office if I become aware of any situation in which that confidentiality of any patient information is breached within 24 hours of discovery, as well as take corrective action to mitigate the damages.

I will make all records concerning patient information and disclosure available to the dental office and to the US Department of Health and Human Service.

I understand that if there is a breach in my privacy obligations, my services may be terminated.

I agree to return or destroy all patient information and keep no copies after the termination of my affiliation with this dental office.

I understand that the above restrictions are for the duration of my affiliation with this office and survive termination of my affiliation with this office.

Print Name

Signature

Date