Confidential Buyer Information

Dental Practice Brokers

Name _____ Date _____
Address _____ City_____ State_____Zip Code_____
Telephone HM_____ Office_____ Cell_____
Email_____ How would you like to be contacted?_____
How did you learn about SAS Transitions Dental Practice Brokers? _____

_____

Interest: (Place a ✔)
Associate _____ Practice Purchase_____ General _____
Specialty _____ Type_____
Location: _____
(this must be completed)

Practice Characteristics:
Annual Gross Revenues_____ Compensation after debt service_____
Treatment Opts_____ Facility Sq Ft_____Other_____

_____

Education: Dental Degree/s_____
College/University _____ Year Graduated_____
Residency Program _____ Year Graduated_____

Dental Experience:
Office/Corporation_____City_____State_____
Dates:_____
Office/Corporation_____City_____State_____
Dates:_____Other:_____

_____

Do you have a resume or CV?_____Please attach it to this form. (must present with this form)

Military: (Please state your Military commitment, branch of service, and date of departure)

_____
Are you working with a licensed broker? _____ If so, who or what company_____
What is your relationship with the broker?

_____

FINANCIAL:

Credit status: A+___A____B____less than B____ Have you ever declared bankruptcy? _____
Have you been pre-approved for financing? _____ If yes, lender_____
Will you need 100% financing?_____ Do you have access to earnest money for down payment?_____
If necessary, do you have a co-signer?_____ If yes, relationship_____

I acknowledge that the above information is true and accurate to the best of my knowledge. Must have signature
Signature _____**Date**_____