PURCHASER / ASSOCIATE PROFILE

ADS WATSON, BROWN & ASSOCIATES

Return to:

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PURCHASER / ASSOCIATE PROFILE

Please print and return completed forms.

GENERAL INFORMATION

Designation: __ General __ Specialist: ______________________________

Name: ____ __ D.D.S. __ D.M.D.
First Middle Last

Office/School Address: ____

City: ______________________ State: ______________ Zip: __________

Home Address: ____

City: ______________________ State: ______________ Zip: __________

Your preferred location to direct our correspondence: __ Home __ Office / School
__ Other ______________________

Office Phone: ____________________ Office Backline: ____________________

Office Fax: ____________________ Pager: ____________________

Home Phone: ____________________ Cell Phone: ____________________

Home Fax: ____________________ Email: ____________________

Are you working with another Broker/Consultant? __ Y __ N If Yes, Name: ____________________

PROFESSIONAL ADVISORS

ACCOUNTANT: ____

Firm Name: ____

Address: ______________________ City/State/Zip ______________________

Phone Number: ______________________ May we contact them? __ Y __ N

ATTORNEY: ____

Firm Name: ____

Address: ______________________ City/State/Zip ______________________

Phone Number: ______________________ May we contact them? __ Y __ N

LIFE INSURANCE AGENT: ____

Firm Name: ____

Address: ______________________ City/State/Zip ______________________

Phone Number: ______________________ May we contact them? __ Y __ N

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DISABILITY INSURANCE AGENT: ____________________

Firm Name: ____________________

Address: ____________________ City/State/Zip ____________________

Phone Number: ____________________ May we contact them? __ Y __ N

CASUALTY & GENERAL LIABILITY: ____________________

Firm Name: ____________________

Address: ____________________ City/State/Zip ____________________

Phone Number: ____________________ May we contact them? __ Y __ N

MALPRACTICE CARRIER: ____________________

Firm Name: ____________________

Address: ____________________ City/State/Zip ____________________

Phone Number: ____________________ May we contact them? __ Y __ N

EDUCATION INFORMATION

	Institution	Degree	Date Completed
Undergraduate			
Dental School			
Graduate School/Residency			
Specialty Training			

Board Qualified: __ Y __ N Board Certified: __ Y __ N

PROFESSIONAL PRACTICE EXPERIENCE

A. PRESENT STATUS:

- __ Student
- __ Associate
- __ Military Dentist
- __ Graduate Student/Resident
- __ Private Practicing Dentist
- __ Other ____________________

Number of Years in Present Status: __________

If practicing, please describe your present practice situation: ____________________

____

B. PAST EXPERIENCE:

- __ Associate Number of Years _________
- __ Practice Owner Number of Years _________
- __ Other ____________ Number of Years _________

License Number: ____________________ State: ____________________

License Number: ____________________ State: ____________________

State or Regional Boards which you have passed:

____________________ Date: ____________

____________________ Date: ____________

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____ Date: _______________

Average monthly practice production that you have consistently achieved in the past: $__________/mo.

Have you ever been found guilty, entered a plea of "no contest", or been a party to a consent degree with regard to a:

Malpractice Claim?	__ Y	__ N
Crime involving moral turpitude?	__ Y	__ N
Criminal or civil litigation involving substance abuse?	__ Y	__ N
Charge of Fraud or Tax-Avoidance with regard to any Federal or State taxes?	__ Y	__ N
Have you been the subject of any disciplinary proceedings by the State Dental Board?	__ Y	__ N
Are there any unsatisfied judgments against you or any business you have owned?	__ Y	__ N

If Yes, please explain: ____

____

____

HEALTH INFORMATION

Do you require any reasonable accommodations in order to perform the essential functions of the position for which you are applying?	__ Y	__ N
Do you currently have any infectious diseases that ethically you feel should be disclosed to potential patients?	__ Y	__ N

If Yes, please explain: ____

____

____

PRACTICE SPECIFICATIONS

A. LOCATION PREFERENCE:

__ No Preference	__ Medium Sized Community
__ Smaller Community	__ Major Metropolitan Urban or Suburban Area

Please list your preferences by priority

AREA		**CITY**	
First	____________________	First	____________________
Second	____________________	Second	____________________
Third	____________________	Third	____________________

Preference:	__ Professional Building	__ Strip Center
	__ Stand Alone	__ Other ____________________

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B. PRACTICE CHARACTERISTICS:

Desired Situation: __ Association __ Purchase Practice __ Startup
__ Associate w/Buy-Out __ Associate w/Buy-In

Availability Date: ___________________

Income Requirement: Minimum $______________ Desired $______________
Present Income $______________

Gross Production: $__________________

Number of Operatories: ___________ Number of Staff: ___________

Importance of Equipment Age: ___________

Other specifications you may require: ____

Time-Frame of Acquisition: ____

ADDITIONAL REQUESTED INFORMATION

Please attach a copy of each of the following:

__ Texas Dental License __ DEA Permit
__ Curriculum Vitae __ Alien Registration Card

Please indicate any other special preference, notes or instructions:

I acknowledge and agree that the information provided in this form is intended to be and will be disclosed to persons (including corporations, partnerships, firms and other individuals) for the purposes contemplated and that Watson, Brown & Associates shall have no liability for any claims, demands or action arising in connection herewith.

To the best of my knowledge, all of the information I have provided is accurate and correct.

_______________________ _______________________ _______________
Please Print Your Name *Signature* *Date*

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