



Confidential Purchaser Profile

The information requested in this profile will enable your transition consultant to gain a valuable insight into your particular needs and goals. It will also allow us to help you derive the maximum benefits from your consultation. Please complete this profile as thoroughly as possible. We would also really appreciate you taking the time to print legibly. Thank You.

Confidential Purchaser Profile

Personal Information

Name *(please include degree)* _____

Corporate Name *(if applicable)* _____

Practice Type: General Specialty _____

Send mail to: Home Office Email _____

Office Phone Number(s): _____ FAX _____

Office Address _____

_____ Zip Code _____

County / Parish: _____

Home Phone Number(s): _____ Cell: _____

Home Address _____

_____ Zip Code _____

May we call you at the office? Yes No

Date of Birth _____ Place of Birth _____

Social Security # _____

I am: right-handed left-handed

If left-handed, can you use right-handed equipment? Yes No

Residence: own rent

My health is: excellent good fair

Marital Status _____ Spouse's Name _____

Spouse's Date of Birth _____ Spouse's Occupation _____

Name & Ages of Children _____

Hobbies & Interests _____

Sports Activities _____

Clubs / Offices Held _____

Other Languages Spoken _____

Professional

Undergraduate School _____ Graduated in _____

Dental School _____ Graduated in _____

Post-graduate _____ Completed in _____

State Licenses / Regional Boards Held _____

License Number _____

Have you ever been disciplined by a state board or court? Yes No

If Yes, describe _____

Have you ever been involved in a dental profession lawsuit? Yes No

If Yes, describe _____

Professional Organizations _____

 Offices Currently Held _____
 Offices Previously Held _____
 Military - Branch _____ Years _____
 Rank on Separation _____ Year _____
 Other post-graduate training (include degrees) _____
 Additional information you wish to disclose _____

Desired Opportunity Information

Desired situation: practice purchase equity associate non-committed associate
 Date of Availability _____
 Minimum Income Required? \$ _____
 Price range of practice you desire? \$ _____
 Gross Production you are capable of producing? \$ _____
 Location Preference: major metropolitan area specify _____
 medium / large city specify _____
 small community specify _____
 small community specify _____
 no preference
 How long have you looked for an opportunity? _____
 How much money do you have for a down payment? \$ _____

Current Practice Information (if applicable)

Date established _____ Date acquired (if applicable) _____
 Type of Practice: Solo Group Retail Clinic
 Are you office sharing with another doctor? Yes No
 Gross Collections: Last Year: 20 ____ \$ _____ Prior Year ____ \$ _____
 Do you have an associate? Yes No
 Do you think you would enjoy sharing practice responsibilities? Yes No
 What specialty work do you refer out? _____
 What specialty work do you offer? _____
 Are you a provider in any prepaid plans, P.P.O. or other plans? Yes No
 Is this an amalgam-free practice? Yes No
 Is your practice involved in any litigation? Yes No
 If Yes, explain _____
 How many patients do you treat on an average day? _____
 Do you have a computer system in your office? Yes No
 If Yes, what software package do you use? _____
 What are your current office hours?
 Monday _____ Thursday _____
 Tuesday _____ Friday _____
 Wednesday _____ Saturday _____

Consumer Credit Report Disclosure Authorization and Consent

The undersigned, recognizing that his or her individual credit history may be a factor in the evaluation of the credit of the applicant, hereby consents to and authorizes PARAGON, Inc and/or any assignee, lender or funding service that may be utilized to obtain and use a consumer credit report on the undersigned, now and from time to time, as may be needed in the credit evaluation and review process and waives any right or claim they would otherwise have under the Fair Credit Reporting Act in the absence of this continuing consent..

Date

Borrower's Signature

Borrower's Name (Print or Type)

Address

City / State / Zip

Social Security Number (required)

Acknowledgment

The undersigned acknowledges and agrees that any and all information provided to him / her by PARAGON, Inc., regardless of whether said information pertains to a specific practice opportunity and/or information is comprised of various forms and schedules produced and provided by PARAGON, Inc., shall be kept confidential and agrees not to disclose to anyone, or make copies of any of the information, ideas, procedures, practices, programs, concepts, contracts and / or any other tangible data conveyed and entrusted to the undersigned without the prior written consent of PARAGON, Inc.. The undersigned hereby certifies that the information provided herein is true and accurate to the best of his / her knowledge.

Date

Signature

Please tell us how you found out about PARAGON.

- referred by* _____
- saw an advertisement in* _____
- knew by reputation*
- received transaction announcements and recognized some of your clients*
- other* _____