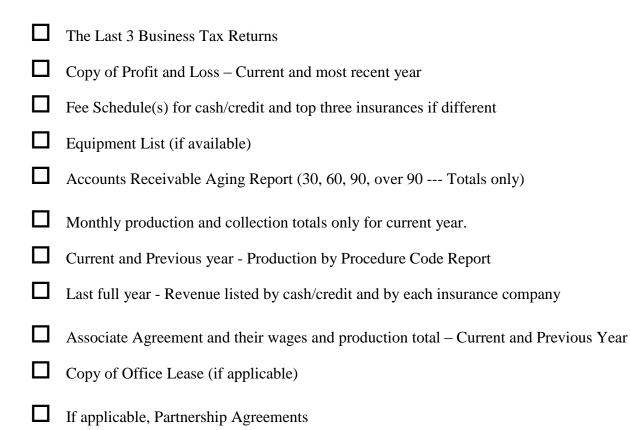
Consani Associates info@mydentalbroker.com (866) 348-3800 fax (866) 348-3809

CONFIDENTIAL PRACTICE QUESTIONNAIRE

Dr. Name:	DDS DMD Spouse:			
Work Address:	Home Address:			
	Home Phone:			
Cell Phone:	E-mail:			
	Home No			
Dental School Attended:	Year Graduated:			
Special Training:				
□ Left Handed □ Right Handed				
Reason for Selling:				
Years with Practice:	_			
Building Information: Sq.Ft	_ # of Operatories:			
Own or Lease Space: If owned (Keep, Sell, or Either):				
If leased (Rent/month amount): If leased (Le	ease end date and Extend options):			
Practice Management Software:				
Doctor's Schedule (Days of week and Hours):				
Names and Percentages of Reduced Fee Programs:				
The description above accurately describes my practice to t				
DrSignature	Date:			

Consani Associates

REQUESTED PRACTICE DATA / REPORTS



Please provide the following staff information:

NAME	TITLE/POSITION	YRS W/PRACTICE	HRS PER WEEK	WAGE

All information remains confidential.

Notes: