DENTAL SERVICES LLC

DATE: _____

The undersigned party below wishes to evaluate confidential business information of one or more professional practice opportunities presented by IG Dental Services, LLC. The undersigned agrees not to disclose to anyone the confidential practice information (other than any advisors of the undersigned, which shall then be bound by the same terms and conditions of this Nondisclosure Agreement). The nature of the dental transition business deals with **highly sensitive** and confidential data, including but not limited to, income tax statements, Proforma, the **names of buyers and sellers**, and/or other tangible or intangible data conveyed and entrusted to the undersigned.

The Seller and IG Dental Services, LLC request that the undersigned return any projections, calculations, word descriptions, and tangible material to IG Dental Services should they decide not to purchase the practice. The undersigned also agrees to delete any confidential data provided electronically through e-mails by the Seller and IG Dental Services, LLC should he/she decide not to purchase the seller's practice.

Full Name
First: _____ Middle: _____ Last: _____ Suffix: _____

Title: ☐ DMD ☐ DDS ☐ Other_____

Mailing Address: _____

HOW WOULD YOU PREFER TO BE CONTACTED? (List all preferred)

- Office Phone: _____
- Home Phone: _____
- Cell Phone: _____
- Email Address: _____

The undersigned has executed this Agreement on the day and year written above.

Signature_____ Date _____

****Please fill out the next page so that we can send you relevant opportunities and to introduce you properly to our sellers.**

DENTAL SERVICES LLC

EDUCATION

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

Board Qualified: ☐ YES ☐ NO Board Certified: ☐ YES ☐ NO

State(s) Licensed In: _____

CURRENT PRACTICE OWNERS ONLY:

Office Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Do you own more than one practice? ☐ YES ☐ NO If yes, how many? _____

GOALS: What is your transition goal date? _____

The Practice Owner would: ☐ Stay on as Associate ☐ Transition completely out ☐ Either

Minimum Criteria: Revenue Size: $_____EBITDA Size: $ _____

No. of operatories: _____ No. of Staff: _____ No. of Associates: _____

Importance of Equipment Age: ☐ High ☐ Low

Location Preference: ☐No Preference ☐Smaller Community ☐Medium Sized Community

☐Major Metro Urban or Suburban Area

City & State: 1st Choice _____; 2nd Choice _____

FINANCIAL SUPPORT

Who will be providing the financial support for this transaction?

☐ Private Bank Loan ☐ Private Equity Company: _____(Name)

☐ DSO: _____(Name) ☐ Self/Cash

If Private Bank Loan, are you pre-qualified? ☐ Yes ☐ No

If yes, which financial institution? _____ How much? $_____

If no, would you like a bank analyst to contact you to discuss? ☐ Yes ☐ NO