NON-DISCLOSURE AGREEMENT

______________________(please enter first and last name, degree or title), hereinafter referred to as "______________" (last name), understands and agrees that any and all information provided to ____________ (last name) by Practice Impact, the business representative for the selling doctor, at any time is confidential ("Confidential Information") and may not be used in any manner by ___________ or his agents, assignees, legatees, heirs, or other legal representatives, without limitation. ____________ agrees that he will not directly or indirectly, in whole or in part, disclose, use, disseminate, or in any manner publish to any person, firm, partnership, association, corporation or business organization, entity or enterprise for any reason or purpose whatsoever said Confidential Information, nor shall ____________ make any claim or right or ownership to any Confidential Information.

For purpose herein, "Confidential Information" shall include, without limitation, any and all information relating to the practice operations, employees, personnel and business relationships, proprietary, unpublished data and documents describing inventions, secret processes, technical information, methods, research and other know-how, patients and/or prospects, terms and conditions of sales and practices, business plans and financial information, technical knowledge relating to patient requirements, and knowledge of markets for the business' products. All Confidential Information disclosed hereunder is a valuable, special and unique asset of the business, disclosure of which would cause immediate and irreparable injury, loss and damage to the business.

______________ may disclose Confidential Information hereunder to employees, his representatives and/or agents of _____________ on an "As Need To Know" basis, provided that such employees, representatives and/or agents first agree in writing to be bound by the terms of this Agreement.

By executing this Agreement, ______________ agrees to receive Confidential Information which may include the Business name which Practice Impact is representing under the terms set forth above. _______________agrees that Facsimile transmissions shall be acceptable as binding. Facsimile transmissions shall be acceptable as legal and binding.

________________ acknowledges Practice Impact is a member of the National Association of Practice Brokers (NaPB) and as such, receives sponsorship from certain lenders. All sponsoring lenders have an agreement with NaPB that any Buyers referred to them shall not include any higher rates and/or fees because of said sponsorship.

If you agree to the foregoing, please confirm this by signing and returning to Practice Impact, the business representative, this Agreement.

This Agreement constitutes the entire Agreement with respect to any Confidential Information provided and supersedes any and all prior understandings, or representations, or agreements. This Agreement shall be construed and the rights of the parties governed under the laws of the State of Ohio.

I agree to the terms and conditions set forth in this Confidential Non-Disclosure Agreement, this ______ day of _____________________, 20__.

____

BUYER QUESTIONNAIRE

Please complete and return to: **Practice Impact**
5071 Forest Drive, Suite A
New Albany, Ohio 43054
Phone: (800) 735-5336
Fax: (614) 939-4705

Personal Information:

Full Name:					
Home Address:					
City:		State:		Zip:	
If student, please provide Summer address:					
How long at permanent address?:					
E-mail address:					
Home Phone:	( )				
Cell Phone	( )				
Marital Status:		# of Children:		Date of Birth	

Educational Information:

	Institution	*Degree*	*Year*
Undergraduate			
Dental School			
Advanced Education			
Residency Program			

Practice Specifications:

What type of practice are you looking for? ______________________

Number of operatories preferred: ______________________

Give a brief description of the type of dentistry you want to perform: ______________________

____

____

____

Practice location desired: State(s): ______________________

City(s): ______________________

Please continue on next page

Dental Practice Experience:

________ Associate Number of Years ____________________
________ Practice Owner Number of Years ____________________
________ Other:______________________________ Number of Years ____________________

Dental License Number:		State:	
Dental License Number:		State:	

State or Regional Boards you have passed:

	Date	
	Date	
	Date	

REFERENCES: (Include address and phone number)
DENTAL: ____

____
BANK: ____

____
PERSONAL: ____

____

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

•Felony?	☐ Yes	☐ No
•Malpractice claim?	☐ Yes	☐ No
•Other criminal or civil litigation?	☐ Yes	☐ No
•Charge of fraud or tax-avoidance with regard to any Federal or State taxes?	☐ Yes	☐ No
•Bankruptcy?	☐ Yes	☐ No
•Disciplinary action taken by the State Dental Board?	☐ Yes	☐ No
•Are there any unsatisfied judgements against you or any business you have owned?	☐ Yes*	☐ No

*If yes, please explain:
____
____

What are you doing at the present time?
____
____

If presently working, how long have you worked for current employer?
____

The undersigned dentist hereby warrants and represents that the statements and answers made above are true and that there are no omissions or misrepresentations of information given.

Signed________________________________ Date____________________