

***PURCHASER AND
ASSOCIATE
APPLICATION***

*ADS Lovelace and Associates, Inc.
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Practice Transitions Made Perfect*

General Information and Location Preference

To give you the best results possible, please fill this form out and return to us as soon as possible. If you want to make any changes after we have received this information, call our office and we will update your file.

Date _____

Name _____

Date of Birth _____ **Social Security Number** _____

Office Address _____ **City, State, Zip** _____

Home Address: _____ **City, State, Zip** _____

Indicate where you prefer we direct our correspondence to you:

Office *Home* *Cell* or *Email*

Please do not give a number that we may not call:

Office Phone _____ **Best time to reach you at office?** _____

Home Phone _____ **Best time to reach you at home?** _____

Cell Phone: _____ **Best time to reach your cell?** _____

Email Address: _____

Present Practice Situation

Where do you work now? _____ **Specialty** _____

How long have you practiced dentistry _____ **?**

How many offices have you practiced in since Graduation? _____

Desired Situation:

Purchase Practice _____ **Equity Associate** _____ **Associate** _____

Date of Availability _____

Single or **Married** **Spouse Name** _____ **Number of Children** _____

Year of _____ **School of** _____

Graduation _____ Graduation _____ Date of Birth _____

Which state or regional boards do you hold? _____

Have you ever been disciplined by a state board or court? _____ Describe _____

Have you ever been involved in a dental practice related lawsuit? Describe _____

Price range of practice you are looking for _____

Gross you are capable of performing _____

Location Preference (Please check all that apply)

_____ Louisiana

_____ Mississippi

_____ Major metropolitan urban and suburban area

Specify City _____

_____ Medium/large city outside of major metro area

_____ Smaller Community

_____ Rural

_____ No preference

What type of practice are you looking for?

of ops _____

Amount you wish to take home annually? _____

Days per week you would like to work _____

Will you accept the following types of income in a practice?

_____ Welfare Capitation _____ Discount Plans _____

Days off desired? _____

How did you hear about ADS Lovelace and Associates, Inc.?

Financing:

Do you have any money available for a down payment? _____ if yes specify amount _____

Do you have any money available for Operating Capital? _____ if yes please specify amount _____

Please attach a copy of the following:

Dental License

DEA Permit

Driver's License

Alien Registration Card (if needed)

Curriculum Vitae

Consumer Credit Report Disclosure Authorization:

The undersigned individual(s), recognizing that his and/or her individual credit history may be a factor in the evaluation of the credit of the applicant, hereby consents to and authorizes ADS Lovelace and Associates, Inc. and 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.

Borrower's Signature

Date

Borrower's Name PRINT

Address

City/State/Zip

Social Security Number