

**SUMMIT DENTAL CONSULTANTS, LLC  
PERSONAL DATA FORM**

**\*required information only for financing**

1. **Full Name:** \_\_\_\_\_
2. **Home Address:** \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. **Home/Cell Phone Number:** \_\_\_\_\_
4. **E-Mail Address:** \_\_\_\_\_
5. **Present Work Address:** \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
6. **Present Work Number:** \_\_\_\_\_
7. **Birth Date:** \_\_\_\_\_
8. **\*Social Security #:** \_\_\_\_\_
9. **Marital Status:** \_\_\_\_\_  
Spouse's Full Name \_\_\_\_\_  
Spouse's Birth Date \_\_\_\_\_  
Spouse's Social Security Number \_\_\_\_\_
10. **No Of Children:** \_\_\_\_\_
11. **Education:** \_\_\_\_\_  
Undergraduate School \_\_\_\_\_  
Location \_\_\_\_\_  
Year of Graduation \_\_\_\_\_ Degree \_\_\_\_\_  
Post-Graduate School \_\_\_\_\_  
Location \_\_\_\_\_  
Year of Graduation \_\_\_\_\_ Degree \_\_\_\_\_  
Residency Program Attended \_\_\_\_\_  
Location \_\_\_\_\_  
Length of Program \_\_\_\_\_  
Year Finished \_\_\_\_\_
12. **Past Work Experience:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. **\*References: (Include address and phone number)**  
Dental: \_\_\_\_\_  
\_\_\_\_\_  
Bank: \_\_\_\_\_  
\_\_\_\_\_  
Personal: \_\_\_\_\_  
\_\_\_\_\_
14. **\*Credit History:**  
If there is anything in your past credit history which would negatively affect your ability to obtain financing, please explain.  
\_\_\_\_\_  
\_\_\_\_\_
15. **\*Have you ever been sued for malpractice?** Yes \_\_\_\_ No \_\_\_\_
16. **\*Dental License Number:** \_\_\_\_\_

