

Date: _____

SDDA Membership Application

Name _____
(last) (first) (middle)

County _____

Office Address _____

Dental District _____

City/State/Zip _____ Phone _____

Fax _____ E-mail Address _____

Home Address _____

Preferred Mailing Address:

City/State/Zip _____ Phone _____

Office _____ Home _____

Partner/Associate _____

Satellite Office _____

of hours at satellite per week _____

ADA ID Number _____ Social Security Number _____

High School Attended _____ Year Grad _____

Pre-Dental School _____ Year Grad _____
(name) (address)

Dental School _____ Year Grad _____
(name) (address)

Graduate School _____ Year Grad _____
(name) (address)

State Boards Taken _____ SD License # _____ Specialty _____

Birth Date _____ Place of Birth _____ Spouse's First Name _____

Children's Names _____

Hobbies _____

Political Offices Held _____

Membership in Organizations, Clubs, Churches, Lodges _____

Have you been a continuous ADA member since graduation: Yes _____ No _____

Have you practiced in any other State: Yes _____ No _____ Which state _____

Are you now in the active practice of dentistry: Yes _____ No _____

Were you a member of ASDA (American Student Dental Assoc)? Yes _____ No _____
If yes, which year: Junior _____ and/or Senior _____

PLEASE COMPLETE THIS FORM AND RETURN TO:

South Dakota Dental Association

PO Box 1194

Pierre SD 57501