



# South Dakota DENTAL ASSOCIATION

A CONSTITUENT OF THE AMERICAN DENTAL ASSOCIATION

## Allied Student Membership Application

804 N Euclid; Ste 103; Pierre SD 57501 • 605-224-9133 • Fax 605-224-9168 email: info@sddental.org • [www.sddental.org](http://www.sddental.org)

(Please print **or type**) I hereby make application for membership in the South Dakota Dental Association.

Name: \_\_\_\_\_  
(last) (first) (middle)

Date of Birth: \_\_\_\_\_ Hygiene Student Dental Assisting Student (Circle one)

Home Address: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Use as my primary mailing address

School Year Address: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip \_\_\_\_\_  
 School Phone: \_\_\_\_\_  
 Use as my primary mailing address

Primary Email Address: \_\_\_\_\_

### Dental Education Program

School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Anticipated Year of Graduation \_\_\_\_\_

### Personal

Marital Status Married Single

Spouse's Name (include last name if different) \_\_\_\_\_

Are you interested in volunteering for community presentations, oral screenings, and health fairs?

yes no not at this time

Enclosed is my completed application and  
check # \_\_\_\_\_ made payable to:

*South Dakota Dental Association  
PO Box 1194  
Pierre SD 57501*

Please charge my \$35.00 dues to the following card:

Visa Mastercard

Card # \_\_\_\_\_

Expires \_\_\_\_\_ 3 digit code \_\_\_\_\_

Name on Card (please print) \_\_\_\_\_

Signature \_\_\_\_\_