



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

(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 \$120.00 dues to the following card:

Visa Mastercard

Card # _____

Expires _____ 3 digit code _____

Name on Card (please print) _____

Signature _____