



South Dakota Dental Association
A CONSTITUENT OF THE AMERICAN DENTAL ASSOCIATION

Allied Membership Application

PO Box 1194 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: _____ Hygienist Assistant Office Staff (Circle one)

Home Address: _____
City _____ State _____
Zip _____
Home Phone: _____
Use as my primary mailing address []

Office Address: _____
City _____ State _____
Zip _____ County _____
Office Phone: _____
Office Fax: _____
Use as my primary mailing address []

Primary Email Address: _____

Dental Education Program

School _____ City _____ State _____

Date of Graduation _____

Date of Licensure in South Dakota _____ South Dakota License # _____

Licensed in the following state(s) _____

Personal

Marital Status Married Single

Spouse's Name (include last name if different) _____

List your preference(s)

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 \$30 dues to the following card:

Visa Mastercard

Card # _____

Expires _____ Date _____

Signature _____

(feel free to make copies)