

# SACRAMENTO DISTRICT DENTAL SOCIETY AFFILIATE MEMBERSHIP APPLICATION

(Please print clearly)



## Personal Information:

Name _____		ADA No. _____
Have you ever been known by any other name? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security No. _____
If Yes, please state _____		Date of Birth _____
<b>Primary Office Address:</b>		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street _____	Phone _____	Spouse Name _____
City _____	Fax _____	
State/Zip _____	Pager _____	Year of first licensure in the U.S. _____
Email _____		Where? _____
<b>Second Office:</b>		
Street _____	Phone _____	California Dental License No. _____
City _____	Fax _____	Year licensed _____
State/Zip _____	Pager _____	
<b>Home:</b>		<b>Mailing Address to be used for all correspondence:</b>
Street _____	Phone _____	(check one)
City _____	Fax _____	<input type="checkbox"/> Primary office address
State/Zip _____	Pager _____	<input type="checkbox"/> Home

## Education:

	School	State/Country	Date	Degree Earned
Dental School	_____	_____	_____ to _____	_____
Internship	_____	_____	_____ to _____	_____
Postgraduate	_____	_____	_____ to _____	_____