(Please print or type)

Name: ____

Office Address: ____

Office Phone: _____-_____-______

Office Fax: _____-_____-_______

Home Address: ____

Home Phone: ____________________

**Which address would you want your mail to be delivered? 0 Home 0 Office*

Email Address: __________________________

Date of Birth: ____-____-______ SS# _____-____-_____

ADA #______________________________

I am a member of the ____
State (Constituant) Dental Society of the ADA

Signature: ____________________________________ Date: ______________________

Complete the information above and return it, along with your payment to:

Southern Maryland Dental Society,
4920 Niagara Road, Suite 306
College Park, Maryland 20740.

Checks are to be made payable to the Southern Maryland Dental Society (SMDS).
We do not take credit cards.
For additional information, please call 301-345-4196.