

MIAMI DADE DENTAL SOCIETY

Membership Application

Name : _____

Degree: DMD DDS Other: _____

Florida license number: _____ Year: _____ ADA Number: _____

Date of Birth: _____

Email Address: _____

Dental School: _____

Graduation date: ____/____/____

Postgraduate program: _____

Beginning date: _____ Completion date: _____

Certificate/Degree: _____

Please indicate primary mailing address: Office Home

Office Address

Street: _____

City: _____ State: ____ Zip: ____

Phone: (____) : _____ Fax: (____) : _____

E-Mail _____ Web site: _____

Home Address:

Street: _____

City: _____ State: ____ ZIP : ____ County: _____

Phone: (____) _____

Signature: _____

Please mail your application and your check payable to MDDS in the amount of \$275 to:

RomanoPerio & Associates, P.A.
7701 SW 62 Avenue, Suite A-1
South Miami, FL 33143

Keep in mind that our bylaws require that you must be a member of the ADA in order to join any affiliate. If you are not sure if you are an ADA member, call the SFDDA at (305) 667-3647 and they will check for you.

For MDDS Office Use Only

Date application received: _____ Amount \$ _____

Signature of authorized affiliate officer: _____ Date: _____