MEMBERSHIP REGISTRATION FORM

ACADEMIC YEAR OF 2020-2021

First Name: ______________________________ Last Name: ______________________________

Credential (s): ____________________ AGD member: ❑ Yes ❑ No AGD #: ________________

Practice Name: ____

Address: ____

Office Phone: ______________________________ Fax: ________________________________

Mobile Phone: __________________________ Email: _________________________________

Preferred methods of contact (can select more than one):

❑ Phone Call #___________________ ❑ Text Message #___________________ ❑ Email ❑ ALL

Special Dietary Requirements (please specify): ____

Shirt Size (select one): ❑ XS ❑ S ❑ M ❑ L ❑ XL ❑ XXL

Member Profile

Specialty/Practice Focus:	
Date of Birth:	Year Started Practice:
Dental School:	Number of Staff in Practice:
Undergrad Degree/Studies:	
Hobbies/Interests:	

Payment Information

Tuition: $1,685 Method of Payment: ❑ Check (made out to Dr. Scott Frank, Ltd.)

❑ Credit Card *($35 card fee applied)*

Amex /Disc / MC / Visa # ________________________ Exp. Date: ___ /___ CVS # ______

Name on card: ____

Billing Address: ____

Email: lela@smilesurgery.com
Fax: (847) 276-2501
Mail: 1411 McHenry Rd. Suite 127, Buffalo Grove, IL 60089