



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 Credit Card (\$50 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