ENROLLMENT FORM

Participating Dentist or Group Practice Name: ____

Tax ID or SS #: ____

In case of Group Practice, Name of Principal Dentist: ______________________________________

Date of Birth: __________________________ Dental School: ________________________________

Board Certified: _____________ Year: _____________ State License #: ______________________

Exp. Date: ___________ Good Standing: Yes / No_______ Language Spoken: ________________

Specialty Licensed?: Yes/No Area of Specialty: _______________________________

LOCATION: 1

Dental Office Name: ____

Street: ____City: ________________________

State: _______________ Zip: ____________

Tel. No.: ( ) ______________ Fax No.( ): ______________ E-Mail: _________________

Tax ID: _______________________________

LOCATION: 2

Dental Office Name: ____

Street: ____City: ________________________

State: _______________ Zip: ____________

Tel. No.: ( ) ______________ Fax No.( ): ______________ E-Mail: _________________

Tax ID: _______________________________

Any additional locations may be added on a separate piece of paper in the same format.

____________________________________ ____________________

Doctor's Signature / Authorized Signatory Date