

# Dallas County Dental Society Member Profile Form

ADA# \_\_\_\_\_

Social Security # \_\_\_\_\_

**Name:** (List how you want it to appear in the roster)

Nickname \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Middle (or initial) \_\_\_\_\_

## General:

Gender  Male  Female Birth Date \_\_\_\_\_ Spouse Name \_\_\_\_\_

Ethnic Origin:  American Indian  Asian  African American  Hispanic  Caucasian  Other

E-mail address \_\_\_\_\_

Web-Site address \_\_\_\_\_

## Military Service:

Branch \_\_\_\_\_ Date Service Began \_\_\_\_\_ Release Date \_\_\_\_\_

Do you wish your name included on mailing labels?  Sell Name  Public Referrals (average 15 a day)

Are you incorporated?  Yes  No Business name if different than your own \_\_\_\_\_

Primary Mailing Address  Home  Office

## Office One:

Address \_\_\_\_\_

Suite Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

Facsimile Number (\_\_\_\_) \_\_\_\_\_

## Office Two:

Address \_\_\_\_\_

Suite Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

Facsimile Number (\_\_\_\_) \_\_\_\_\_

## Office Three:

Address \_\_\_\_\_

Suite Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

Facsimile Number (\_\_\_\_) \_\_\_\_\_

## Home:

Address \_\_\_\_\_

Apartment Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Telephone Number (only if you want published in Roster) (\_\_\_\_) \_\_\_\_\_

## Education:

Dental School \_\_\_\_\_

Graduation Year \_\_\_\_\_

Degree \_\_\_\_\_

Graduate School \_\_\_\_\_

Graduation Year \_\_\_\_\_

Degree \_\_\_\_\_

Specialty Certificate \_\_\_\_\_

Specialty \_\_\_\_\_

License Number \_\_\_\_\_ State \_\_\_\_\_

License Number \_\_\_\_\_ State \_\_\_\_\_

## Specialty:

- Dental Public Health
- Oral & Maxillofacial Surgery
- Orthodontics
- Prosthodontics

- Endodontics
- Oral & Maxillofacial Pathology
- Pediatric

- General
- Oral & Maxillofacial Radiology
- Periodontics

## Type of Practice:

- Sole Owner
- Full-time (over 30 hours per week)
- Full-time practice/Part-time faculty
- Armed Forces
- Hospital Staff Dentist
- Other Occupation
- Associate
- Part-time (under 30 hours per week)
- Part-time faculty/Part-time practice
- Federal Services
- Graduate Student/Resident
- No longer in practice
- Faculty
- State/local government
- Other Non-Dental Student

Foreign Languages: \_\_\_\_\_

## Affiliations:

Are you related to another dentist?  Yes  No If so, who? \_\_\_\_\_

Do you know an elected official well enough to call him/her?  Yes  No

If so, who? \_\_\_\_\_ Position \_\_\_\_\_