ELITE
DENTAL GROUP LTD

MEMBERSHIP REGISTRATION FORM

ACADEMIC YEAR OF 2017 – 2018

First Name: _____ **Last Name:** _____

Credentials: _____ **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:	**Years Started Practice:**
Dental School:	**Number of Staff in Practice:**
Undergrad Degree/Studies	
Hobbies/Interests:	

Payment Information

Tuition: $2,195 **Method of Payment:** ❑ **Check** ❑ **Credit Card** *($50 card fee applied)*

Amex /Disc / MC / Visa # _____ **Exp. Date:** ___ /___ **CVS #** _____

Name on card: _____

Billing Address: _____

Return by Mail to 1411 McHenry Rd. Suite 127, Buffalo Grove, IL 60089 | Return by Fax to (847) 276-2501

or Return by Email to chinta@smilesurgery.com (scan or photograph)