



MEMBERSHIP APPLICATION

NAME (As you wish it to appear on membership certificates, website listing, etc.)

First _____ Initial(s) _____ Last _____ Degree(s) _____

ADDRESS

Practice/Business Name _____

Address _____ Suite _____ City _____ State _____ Zip _____

Office Telephone _____ Office Fax _____

Cell Phone _____ Email Address(s) _____

Office Web Site Address(s) _____

Doctor's Home Address _____ City _____

State _____ Zip _____

Personal E-Mail address(s) _____

EDUCATION and TRAINING

Undergraduate School _____ Degree(s) _____ Year _____

Dental School _____ Degree(s) _____ Year _____

Specialty or Post-Graduate Studies _____

_____ Degree(s) _____ Year _____

Please indicate area of practice:

General Practitioner

Oral & Maxillofacial Surgeon

Periodontist

Prosthodontist

Endodontist

Implantologist

IMPLANT DENTISTRY EXPERIENCE

Implant continuing education hours in last 3 years: _____

Experience in implant dentistry: less than 10 cases

10-49 cases

50- 100 cases

more than 100 cases

AMERICAN DENTAL IMPLANT ASSOCIATION MEMBERSHIP APPLICATION

ANNUAL MEMBERSHIP

Membership Dues \$300

MEMBERSHIP DUES INCLUDE:

- ▲ Newsletter subscription
 - ▲ Access to article archive
 - ▲ Membership pin
 - ▲ Patient consent and communication forms to use in your practice
 - ▲ Framed certificate of membership
 - ▲ Certification program: Fellowship, Mastership and Diplomate credentials
 - ▲ Registration to the American Dental Implant Association Annual Symposium at a discounted cost
 - ▲ Listing in the Membership Directory and link to your practice at www.theamericandentalimplantassociation.com
 - ▲ Daily access to the online Q & A with expert faculty
 - ▲ Special member product discounts
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PAYMENT INFORMATION

Return this application with your membership dues to:

The American Dental Implant Association
1840 NE 153rd Street
North Miami Beach, FL 33162

Checks: Please make checks payable to **The American Dental Implant Association** at the address above.

Credit Cards: Please complete the following information

MasterCard Visa American Express Discover

Card # _____

Exp. Date _____ Billing Zip Code _____

Signature _____



1840 NE 153rd Street
North Miami Beach, FL 33162
email: info@americandentalimplantassociation.com

FOR MORE INFORMATION, CALL FIORELLA SAMANIEGO AT 305-206-0364