Personal and Home Mailing Information

ADA Number (if known) _____ Degree (*Required) ☐ D.M.D. ☐ D.D.S Sex ☐ M ☐ F

Name (*Required)
First Last Middle Alias/Previous/Maiden

Street Address _____ Date of birth ___/___/___
MM DD YYYY

Suite or Unit # _____ City _____ State/Zip/County _____

Cellular Phone ( ) _____ Work Phone ( ) _____ Home Phone ( ) _____

Permanent Email (non .edu) _____

Race (*Required) ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other ☐ Prefer Not to Answer

Post Graduation Mailing Address

Do you know your post-graduation mailing address? ☐ Yes ☐ No

If so, is it your: ☐ Office ☐ Home ☐ School

Start Date for New Address ___/___/___
MM DD YYYY

Street _____ Suite or Unit # _____

City _____ State/Zip/County _____ Phone ( ) _____

Email _____

Biographical and Education

Dental School (*Required) _____ Graduation Date (*Required) _____

What state do you intend to be licensed and practicing in? _____

Post-Doctoral/Resident Information

Have you been accepted into a full-time residency or advanced education program of not less than one academic year's duration?
☐ Yes ☐ No

If yes, please indicate:

School/Hospital _____ Address _____

City _____ State/Zip/County _____

Specialty ☐ Endodontics ☐ Pediatric Dentistry ☐ Periodontics ☐ Public Health ☐ Prosthodontics
☐ Orthodontics and Dentofacial Orthopedics ☐ Oral & Maxillofacial Pathology ☐ Oral & Maxillofacial Radiology
☐ Oral & Maxillofacial Surgery ☐ General Practice Residency or Advanced Education in General Dentistry Program
☐ Other: _____

Program Start Date ___/___/___ Completion Date ___/___/___
MM DD YYYY MM DD YYYY

Over →

Military Service

If you are practicing or will be practicing in the Federal Dental Services, please indicate which branch

☐ U.S. Air Force ☐ U.S. Army ☐ U.S. Navy ☐ U.S. Dept. of Veteran Affairs ☐ Other: _____

☐ U.S. Public Health Service Agency: _____

In-Service Date ____ / ____ / ____
MM DD YYYY

Applicant Signature (*Required)

☐ By checking this box, you agree to irrevocably give permission to the American Dental Association and your State or Local Dental Society where you participated in the National Signing Day (collectively, the "Organizations" and individually, an "Organization"), and their respective officers, agents, subsidiaries, affiliates, assignees, licensees, successors and designees, to take and use photographs, audio, and/or video recordings ("Images") taken of you at the National Signing Day event which you have or will participate in.

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You are of legal age and have read the foregoing and fully understand the contents thereof.

I hereby apply for membership in the American Dental Association and resolve to abide by the *Bylaws and Principles of Ethics and Code of Professional Conduct* if accepted into membership.

Signed _____ Date ____ / ____ / ____
MM DD YYYY

Your society will contact you if payment is required. Do not send payment now.