

LOUISIANA DENTAL ASSOCIATION
TRIPARTITE MEMBERSHIP APPLICATION

7833 Office Park Blvd., Baton Rouge, LA 70809
 Telephone: 225.926.1986 | Fax: 225.926.1886
 www.ladental.org



MEMBER INFORMATION

Name: _____ DDS DMD Other _____
 ADA Number: _____ Date of Birth: / / _____ LA State Board of Dentistry License #: _____

OFFICE ADDRESS

Office Street Address: _____
 Office City/State/Zip: _____
 Office Number: _____ Office Fax Number: _____ Email: _____

HOME ADDRESS

Home Street Address: _____
 Home City/State/Zip: _____
 Home Number: _____ Cellular Number: _____

Preferred Mailing Address: Office Home

SPOUSE INFORMATION

Spouse Name: _____ Is spouse a dentist? Yes No

BIOGRAPHICAL

Dental School: _____ Graduation Date: _____
 Advanced Education Program (School/Hospital): _____ Completion Date: _____
 Program Area(s): Endo Pediatric Perio Public Health Prosthodontics Orthodontics Oral Path Oral Surgery
 General Practice Other _____

Is your practice limited to the above specialty? _____ Yes _____ No

Indicate if: Currently practicing Look for a dental practice opportunity in _____ (city) _____ (state)

Indicate if practicing in, or looking for: Solo Group Partnership Associateship
 Clinic Faculty Other _____

CURRENT ADA MEMBERSHIP

Current member in (state society) _____ with dues paid for the 20____ membership year.

I was referred/recruited to membership by Dr. _____

SIGNATURE

I hereby make application for membership in the _____ (local component) Dental Association, Louisiana Dental Association and the American Dental Association. If accepted, I will abide by the Bylaws of these associations.

Signature of Applicant: _____

Date: _____