



Greater St. Louis Dental Society

Associate Member Application

11457 Olde Cabin Road, Suite 300

St. Louis, Missouri 63141

314-569-0444 / Fax 314-569-0448

www.gslds.org / gslds@gslds.org

Name: _____

ADA # _____ Social Security # _____

Office Address: _____

_____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Practice Name: _____

E-Mail Address: _____ Office Website: _____

Home Address: _____

_____ Zip Code: _____

Home Phone: _____ Birthdate: _____

State Association: _____ Local Society: _____

General Practice _____ Specialty _____

(List Specialty)

Dental School: _____ Date of Graduation: _____

Graduate School: _____ Date of Graduation: _____

Dental License #: _____ State: _____ Date Issued: _____

Specialty License #: _____ State: _____ Date Issued: _____

I hereby make application for Associate Membership in the Greater St. Louis Dental Society and remit herewith the sum of \$75.00 as dues for the calendar year _____

Check Visa MasterCard

Card No.: _____ Expiration Date: _____

CC Billing Address/Zip Code: _____

Signature: _____ Date: _____

Please complete and return with dues to:

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St. Louis, MO 63141