

### 1. GENERAL INFORMATION

LAST NAME

FIRST NAME

BILLING ADDRESS

APT./SUITE

CITY

STATE

ZIPCODE

Phone Number: \_\_\_\_\_

ADA Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Kosher/Vegetarian?: \_\_\_\_\_

### 2. REGISTRATION

If registering staff, please indicate name(s): \_\_\_\_\_

COURSE NUMBER	TITLE	DATE	TUITION

### 3. PAYMENT *(Make checks payable to **Second District Dental Society** written in full.)*

Check or Money Order (must be received **one week before course date** to secure reservation)

**Credit Card (Debit cards not eligible):**  Mastercard  Visa  American Express  Discover

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_

CVV/CVC Code: \_\_\_\_\_

*(The three/four-digit number located on front/back of card)*

Cardholder Signature: \_\_\_\_\_

#### Mail or fax completed form to:

Second District Dental Society  
111 Fort Greene Place  
Brooklyn, NY 11217  
Phone: (718) 522-3939  
Fax: (718) 797-4335