



**HISPANIC DENTAL ASSOCIATION  
PRE-DENTAL MEMBERSHIP APPLICATION**

**NAME (First/Middle/Last)** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**CITY/STATE/ZIP:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**SCHOOL INFORMATION**

**Name of Current School:** \_\_\_\_\_

**Date of Graduation:** \_\_\_\_\_ **Degree Expected:** \_\_\_\_\_

**CURRENT STATUS:**

**Middle School**  **High School**  **College**  **Post Grad**

**Post Graduate Program** \_\_\_\_\_

**Does your school have a Pre-Dental Student Chapter?** \_\_\_\_\_

**If YES, what is the name/contact info of your Faculty Advisor?** \_\_\_\_\_

**SURVEY INFORMATION (Optional)**

**1. What services would you like to derive from HDA membership?** \_\_\_\_\_

**2. Are you willing to participate in community activities arranged by your chapter or the National HDA?**

**YES**

**NO**

**3. What is your ethnicity?** \_\_\_\_\_

**4. How did you hear about HDA BOLD Program?** \_\_\_\_\_

**PLEASE COMPLETE THIS APPLICATION AND SEND ALONG WITH YOUR \$25.00 STUDENT MEMBERSHIP DUES TO: Email: [membership@hdassoc.org](mailto:membership@hdassoc.org)**

**Mail: *421 Huguenot St. Suite 54  
New Rochelle, NY 10801***

**Make Check or Money Order payable to: H i s p a n i c D e n t a l A s s o c i a t i o n**

**Payment by Credit Card (Circle one) Visa MC Discover AMEX**

**CC# \_\_\_\_\_**

**Exp. Date: \_\_\_\_\_ Security Code: \_\_\_\_\_**

**Name on Card: \_\_\_\_\_**

**Billing Address: \_\_\_\_\_**

**City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_**

**Auto-Renew \_\_\_ Yes \_\_\_ No**