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? ____________________________

www.hdassoc.org
PLEASE COMPLETE THIS APPLICATION AND SEND ALONG WITH YOUR $25.00 STUDENT MEMBERSHIP DUES TO: Email: membership@hdassoc.org
Mail: 2 Talon Ct. Sewell, NJ 08080

Make Check or Money Order payable to: Hispanic Dental Association

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

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