HISPANIC DENTAL ASSOCIATION
PREDENTAL 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