SOUTHWEST ACADEMY OF COMPREHENSIVE DENTISTRY

2008-2009 Member Registration

Doctor Name: ___________________________________ **Doctor Birth Date**__________________

Address: ____

City/State/Zip: ____

AGD Member Yes # _______ / No______

Spouse/Significant Other: ____

Phone: _______________________________ Fax: ____________________________

Email: ____________________________Preferred mode of communication: _________

Main Contact Person ____

Doctor Dietary Considerations____

STAFF MEMBERS PARTICIPATING IN AUXILIARY PROGRAMS

Front Office/Administrative	**Job Title**
1.______________________________	**1.**______________________________
2.______________________________	**2.**______________________________
3.______________________________	**3.**______________________________

Clinical Staff	**Job Title**
1.__________________________	1.__________________________
2.__________________________	2.__________________________
3.__________________________	3.__________________________

Tuition of $1,200 for complete program, including all auxiliary events. Please make checks payable to SACD or complete card information below.

MC/V AMEX # _____________________________________ exp _________

Name on Card ____

Signature ____

8800 Katy Freeway, Suite 210, Houston, TX 77024 713-464-2833