



Buncombe County Dental Society

Membership Application

Check One: **New Member** **Associate Member** **Honorary Member**

Date: _____

Full Name _____ DDS DMD

Date of Birth: ____/____/____ Specialty: _____

NC Dental License #: _____ Sex: Male Female

Government Employed: Yes No ADA Member: Yes No

Marital Status: _____ Spouse Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ E-Mail: _____

Practice: _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Office Administrator: _____ Practice E-Mail: _____

Phone: (____) _____ Fax: (____) _____

Education:

Pre-dental: _____ Degree: _____ From: _____ to: _____

Dental: _____ Degree: _____ From: _____ to: _____

Post Grad./Other: _____ Degree: _____ From: _____ to: _____

If elected to membership, I agree without reservation to conduct myself professionally and personally according to the principles of dental ethics and to be governed by the constitution and by-laws of the Buncombe County Dental Society.

THIS APPLICATION WAS ELECTED TO
BCDS MEMBERSHIP EFFECTIVE:

(Signature)

(Buncombe County Dental Society)

(Date)

(Date)

- INSTRUCTIONS:
1. Print and complete all areas of application.
 2. Mail application with yearly dues of \$250 to:

BCDS ~ 304 Summit Street ~ Asheville, NC ~ 28803

Questions?? Contact us at 828-274-0498 Fax:828-274-2093 Email: Denise@bcdentalsociety.org