

AADGP Membership Application



We/I hereby apply for membership in the American Academy of Dental Group Practice and agree to abide by the Constitution and bylaws of the Academy.

Name of Organization _____
Address of Organization _____
City _____ State _____ Zip _____
Phone () _____ Fax () _____ Email _____
Primary Contact Person _____ Date: _____

Please indicate membership category you are applying for (*AADGP reserves the right to review & correct membership category & charge or bill the difference as necessary*):

- Dental Group Practice: \$150.00**
(Initial year fee is \$150 per group. Thereafter, annual dues are \$150 per group, plus \$75 for a primary administrator and \$10 per each dentist and each additional member of the group.)
List dentists and/or practice administrators to be included in membership (Attach additional sheets if necessary):
1. _____ 3. _____
2. _____ 4. _____
- Individual Practitioner / Dental Office Administrator: \$150.00**
(Initial year fee is \$150 per solo practitioner/dental office administrator. Thereafter, annual dues are \$150 per solo practitioner/dental office administrator.) Person's Name _____
- Government or Educational Organization: \$100.00**
(Initial year fee is \$100 per group. Thereafter, annual dues are \$75 per group.)
Primary Contact Person _____
- Corporate Member: Annual fee is \$500.00 per organization.**
(Any company that provides services to dental group practices, and whose concept of dental care delivery coincides with the philosophy and purpose statement of this Academy.)
President/CEO's Name _____
(Choose one) Labels by Practice _____ Labels by Dentist _____
- Associate Member: Annual fee is \$500.00 per organization.**
(Practice management companies or individuals that own, develop and/or manage the business and/or marketing activities of dental group practices and facilities.)
President/CEO's Name _____

Payment can be made by check or credit card:

Check Enclosed, Payable to **AADGP** Check Number: _____

Charge my:

Visa MasterCard AmEx Diner's Club

CREDIT CARD NUMBER EXPIRATION DATE CSV/CID Code

CARDHOLDER'S NAME(as it appears on the card) CARDHOLDER'S SIGNATURE DATE

CARDHOLDER'S ADDRESS (if same as company address please write "same")

CARDHOLDER'S CITY STATE ZIP/POSTAL CODE

Mail, Fax, or Email application and payment to:

American Academy of Dental Group Practice
2525 E. Arizona Biltmore Circle, Suite 127, Phoenix, AZ 85016

EMAIL: info@aadgp.org
FAX: 602.381.1093