



Dental Assistant Services

Expanded Functions Registration Form

Contact Information

Full Name

Primary Phone

Home Work Cell
Please Select One

Street Address

Secondary Phone

Home Work Cell
Please Select One

City/Town

State

Zip Code

Email Address

Last Four Digits of Social Security Number

Course Information

Start Date of Course
(from [Website](#))

End Date of Course
(from [Website](#))

Start and Ending Time
(from [Website](#))

The full cost of this course is \$. Please call the office at 732-919-1816 for the current rate and to assure that there is an opening in this course.

Questions

1. I would like to be called if there should be an opening for this course at an earlier date.

Yes No

2. I have read and agree to all the [terms and conditions](#) as well as the [copyright notice](#). Please note that you must mark **yes** to the right or you will not be permitted to register for this course.

Yes No



Questions (cont'd)

3. Why are you planning to take this course?

To Prepare for the Exam

For Continuing Education Credits

Exam Prep and CDE Credits

Other, Please specify

Additional Instructions

After completing this registration form in its entirety, please print it out. Sign and date the form below and mail it in along with your \$100 non-refundable deposit made out to Dental Assistant Services. This will reserve your seat in the course. Alternatively, you may bring this form and your deposit to our office in person.

You will be called one week prior to the start of class to confirm your registration. Prior to this, calls will only be made if your registration form is received **AFTER** the course has already been filled. In other words, if you do **NOT** receive a call from us and your bank statement shows that your \$100 has been deposited you can safely assume that your registration has been accepted.

Click [here](#) for additional information about accepted forms of payment.

Signature

I certify that all information on this registration form was completed by me and is correct and accurate to the best of my knowledge.

Signature: _____

Date:

Please mail all registration materials together in one envelope to:

Dental Assistant Services
1306 Highway 33
Suite 3A
Farmingdale, NJ 07727

