

MEMBERSHIP APPLICATION

OREGON DENTAL ASSOCIATION - AMERICAN DENTAL ASSOCIATION – LANE COUNTY DENTAL SOCIETY

INSTRUCTIONS TO APPLICANT: Please print clearly. Each question must be answered fully. Fax completed application to 541-686-2392

Name _____ DDS DMD Other _____
First Middle Last

Date of Birth _____ Preferred Name/Nickname _____ Sex M F

Spouse Name _____ Is Spouse a dentist? Yes No

Primary Office Address _____
Address Office Telephone

Office Email _____ Website _____
City State Zip Office Fax

Practice Model: In order to better serve you, we'd like to know your current primary practice model. If applicable, please name the organization with which your practice is affiliated. Group practice definitions are given on the back side of this page.

- Faculty Solo Private Practice Dentist Owned and Operated Group Practice
- Dental Management Organization Affiliated Group Practice (DM: _____)
- Insurer-Provider Group Practice (Insurer: _____)
- Not-for-Profit Group Practice (Organization: _____)
- Government Agency Group Practice (Agency: _____)
- Hybrid Group Practice (Comments: _____)

Home Address _____
Address Home Telephone

Home Email _____
City State Zip Home Fax

Directory Listing: Address/Phone - Office Home Email - Office Home Do not list Website - Yes No
(The above will be listed on the public portion of the ODA website under "Find a Dentist"; retired dentists are listed under the member portion only of the ODA website)

Preferred Mailing Address: Office Home Preferred Email Address: Office Home

Preferred Phone Contact: Office Home Cell

Prefer to receive ODA communications (check only one): Email Mail

Prefer to receive Membership Matters newsletter via (check only one): Email Mail

Education/Specialty:

Dental School _____ Graduation Date ____/____/____
MM DD YYYY

Advanced Education Program _____ Completion Date ____/____/____
MM DD YYYY

Is your practice limited to a specialty? Yes No Specialty _____

American Board Certified? Yes No Oregon License _____ Year _____

Are/Were you a member of American Student Dental Association (ASDA) Yes No If yes, from ____ to ____
YYYY YYYY

Are you presently a member of the ADA? Yes No ADA Membership Number _____

I am /was a member of the following dental societies: (Give State and local societies or Federal Dental Service)

Has your license to practice dentistry ever been revoked, suspended, or limited for disciplinary reasons? Yes No
(if yes, state facts fully on separate sheet)

If you have ever been known by another name, please state: _____

I hereby agree to abide by the By-Laws, Principles of Ethics and Code of Professional Conduct of the Lane County Dental Society, the Oregon Dental Association, and the American Dental Association.

I recognize that membership in the Lane County Dental Society, Oregon Dental Association, and the American Dental Association is a privilege. I further recognize these organizations are required to investigate the qualifications of applicants and maintain standards of conduct for members.

In order to perform adequately their investigatory and disciplinary functions, these organizations must be free to perform these functions without a fear of litigation by rejected applicants or disciplined members. Therefore, in exchange for their consideration of this application, I hereby release the organizations, their members, and anyone acting on their behalf from liability for damages for any acts performed in connection with the application or disciplinary process. This release includes, but is not limited to, claims for defamation, invasion of privacy, and intentional interference with business relationship, and applies regardless of the intent with which the act is performed. I hereby consent to any investigation of the facts disclosed in my application, to any disciplinary investigation, and to any statements made in connection with the application or disciplinary process, by whomever made and whether defamatory or not.

Signature _____ Date _____

If an ODA Member encouraged you to join, please indicate: Name _____

ADA Group Practice Definitions

Throughout this classification, 'group' refers to two or more dentists that are somehow affiliated with each other.

Dentist Owned and Operated Group Practice: More than one dentist in a single practice that may be located at a single or multiple sites. Completely owned and operated by dentists, usually organized as a partnership or professional corporation.

Dental Management Organization (DMO) Affiliated Group Practice: A group practice that has contracted with a DMO to conduct all of the business activities of the practice that do not involve the statutory practice of dentistry, sometimes including the ownership of the physical assets of the practice.

Insurer-Provider Group Practice: A group practice that is part of an organization that both insures the health care of an enrolled population and provides their health care services.

Not-for-Profit Group Practice: A group practice that is operated by a charitable, educational, or quasi-governmental organization that often focuses on providing treatment for disadvantaged populations or training healthcare professionals.

Government Agency Group Practice: A group practice that is part of a government agency. It is organized and managed completely by the agency. All dentists are government agency employees or contractors and operate according to agency policies.

Hybrid Group Practice: A group practice that does not clearly fit into any of the above categories and can exhibit some characteristics of several of them.