



# CHARLOTTE DENTAL SOCIETY

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1112 Harding Place #200 – Charlotte, NC 28204 – (704) 376-6555 – FAX (704) 376-3173

Dear Prospective Member:

On behalf of the Board of Directors of the Charlotte Dental Society, it is my pleasure to welcome you to the Charlotte Dental Community and extend an invitation to you for membership in our Society. This professional association of over 340 members has the following objectives:

*“...to cultivate the art and science of dentistry, together with its collateral branches; to elevate and sustain the professional character of dentists; to promote among them mutual improvements, social intercourse and good feeling; and to collectively represent and have cognizance of the dental profession in North Carolina.”*

The Dental Society offers its members numerous benefits, including:

- Four regularly scheduled membership meetings with dinner and professional speakers on pertinent dental topics
- Approved credits for state board continuing education requirements
- Networking and fellowship with dental colleagues
- An active peer review program
- The Community Forum newsletter
- Representation and a voice in local and district dental society issues
- Participation on committees that benefit our membership and the community
- Free referral services
- Free membership for new practitioners who qualify

I hope you'll consider joining the Charlotte Dental Society, and helping us perpetuate a long, rich history. Enclosed are forms that will assist you with the application process. If you have any questions or if we can assist you in any way, please do not hesitate to call the society office, 704-376-6555.

Again welcome! I hope to see you at our next membership meeting.

Sincerely,

Eric Kerr, DDS  
President



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## MEMBERSHIP APPLICATION

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Practice Name \_\_\_\_\_

Office Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Home Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employment \_\_\_\_\_

### Membership category (please ✓ one):

*Active.* Member of the dental profession, practicing in Mecklenburg County, licensed according to the dental laws of North Carolina, and member in good standing of the American Dental Society (ADA), the North Carolina Dental Society (NCDS), and the Second District Dental Society. Pay full dues, \$190.00; please submit with application. No cost to attend membership meetings.

*Associate.* Member of the dental profession duly licensed to practice in North or South Carolina, practicing outside of Mecklenburg County. Pay full dues, \$190.00; please submit with application. No cost to attend membership meetings.

*New practitioner associate.* Member of the dental profession, duly licensed in North Carolina, newly practicing in Mecklenburg County, with or without membership in ADA, NCDS, and Second District. Exempt from dues. Must apply for active membership within 12 months of date of New Practitioner Associate Membership.

### Membership status (please ✓ where applicable):

American Dental Association \_\_\_\_\_ North Carolina Dental Society \_\_\_\_\_ Second District \_\_\_\_\_

ADA # \_\_\_\_\_

### EDUCATION:

**Undergrad** \_\_\_\_\_ **Degree** \_\_\_\_\_ **Year** \_\_\_\_\_

\_\_\_\_\_ **Degree** \_\_\_\_\_ **Year** \_\_\_\_\_

**Dental** \_\_\_\_\_ **Degree** \_\_\_\_\_ **Year** \_\_\_\_\_

**Other** \_\_\_\_\_ **Degree** \_\_\_\_\_ **Year** \_\_\_\_\_

**STATE LICENSE #:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I, the undersigned, hereby make application to membership in the Charlotte Dental Society.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

### Sponsorship

Applicants for *active* and *associate* membership must have the signature recommendations of two active members of the Charlotte Dental Society.

1) \_\_\_\_\_

(name) (signature)

2) \_\_\_\_\_

(name) (signature)

### CDS BOARD APPROVAL

**President** \_\_\_\_\_

**Date** \_\_\_\_\_



## CHARLOTTE DENTAL SOCIETY REFERRAL INFORMATION

Please complete the following and return with your membership application to the Charlotte Dental Society office: **1112 Harding Place #200, Charlotte, NC 28204. Phone: (704) 376-6555 – FAX: (704) 376-3173.** Thank you for your cooperation.

### Additional Information

Name: \_\_\_\_\_

Board Certification: \_\_\_\_\_

Hospital Privileges: \_\_\_\_\_

Foreign Language \_\_\_\_\_

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### Referral Information

The Mecklenburg County Medical Society and The Charlotte Dental Society provide a medical and dental telephone referral service for the benefit of the community. This line, **704-376-0847**, is open from 9:00 am to 1:00 pm Monday through Friday and is operated by staff members of MCMS and CDS. It is listed in the Yellow Pages of the telephone directory and is provided at no charge to members. Please complete the following to assist the CDS staff in maintaining an effective referral service.

#### **I will accept referrals for:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cosmetic Dentistry    | <input type="checkbox"/> Crown & Bridge    | <input type="checkbox"/> Endodontics     |
| <input type="checkbox"/> Extractions           | <input type="checkbox"/> Dentures          | <input type="checkbox"/> Facial Pain/TMJ |
| <input type="checkbox"/> General Anesthesia    | <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Implants        |
| <input type="checkbox"/> Maxillofacial Surgery | <input type="checkbox"/> Oral Medicine     | <input type="checkbox"/> Orthodontics    |
| <input type="checkbox"/> Pediatrics            | <input type="checkbox"/> Periodontics      |  |

#### **I accept the following payment options:**

- |   |   |
|---|---|
| <input type="checkbox"/> Medicaid             | <input type="checkbox"/> Credit Card(s)                                       |
| <input type="checkbox"/> Payment Plans        | <input type="checkbox"/> Worker's Compensation Insurance                      |
| <input type="checkbox"/> Insurance Assignment | <input type="checkbox"/> After-hours emergencies for non-established patients |

The most frequent request made regarding the availability of dental services is for the names of dentists who accept Medicaid. The dental society office provides a recorded message with the names and phone numbers of those dentists. To access this recording, patients should call the medical/dental referral line, **704-376-0847**, between 9:00 am and 1:00 pm Monday through Friday. If you accept Medicaid, would you be willing to have your name and phone number included on this recording? \_\_\_\_\_Yes \_\_\_\_\_No

### VOLUNTEER INFORMATION

I am interested in serving as a member of the following standing committees:

- |  |  |                                      |  |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Contact/Crisis  | <input type="checkbox"/> Ethics          | <input type="checkbox"/> New Members | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Discovery Place | <input type="checkbox"/> Explorer Scouts | <input type="checkbox"/> Peer Review | <input type="checkbox"/> Social        |



# ***CHARLOTTE DENTAL SOCIETY***

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## **NEW MEMBER PROFILE**

### **PERSONAL INFORMATION**

**Name:** \_\_\_\_\_

**Nickname:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Hobbies and Recreational Activities:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Spouse's name:** \_\_\_\_\_

**Spouse's occupation:** \_\_\_\_\_

**Spouse's Hobbies:** \_\_\_\_\_

\_\_\_\_\_

**Children's names & ages:** \_\_\_\_\_

\_\_\_\_\_

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## Charlotte Dental Society Auxiliary New Member Application

Dentist's Name \_\_\_\_\_



### **Spouse's Information**

Name \_\_\_\_\_

Home Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Office Address \_\_\_\_\_

Office Phone \_\_\_\_\_