



Registration Form

Doctor's Name: _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

E-mail: _____

Payment Information

Credit Card* Check (enclosed)**

Visa / MC / Disc. #: _____

Exp. Date: ____/____/____ Amount paying: \$1000 (deposit) \$2950 (full amount)

Cardholder's Name: _____

Signature: _____

Billing Address: _____

Confirmation

What type of confirmation you would like to receive? Mail Email Fax

* If paying by credit card, you can fax the completed registration form to (605) 371-3445. A confirmation will be sent to you.

** If paying by check, please make check payable to "Family & Implant Dentistry" and mail with completed form to the address below. A confirmation will be sent to you.

Family & Implant Dentistry
4921 E. 26th St.
Sioux Falls, SD 57110
Phone: (605) 371-3443
Fax: (605) 371-3445
E-mail: implantdental@midconetwork.com
Web: www.drkusek.com