



### CONTACT INFORMATION

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

Name of Practice / Laboratory: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Speciality:

- General Practitioner     Periodontist     Prosthodontist     Orthodontist     Pediatric Dentist  
 Oral Surgeon     Technician     Endodontist     Other: \_\_\_\_\_

### COURSE INFORMATION

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

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

Course Date: \_\_\_\_\_

Hotel     No Hotel    How did you hear about this course? \_\_\_\_\_

### BILLING INFORMATION

VISA     Master Card

Name of Card Holder : \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Billing Postal/Zip Code: \_\_\_\_\_ Card Security Code: \_\_\_\_\_

I have read the terms and conditions attached to this form or on the IDEA website: [www.ideausa.net](http://www.ideausa.net). By signing this form, I agree to the terms and conditions of IDEA.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_