Blue Grass Dental Society

Meeting Registration

Please select the meeting(s) for which you are registering:

☐ Sept. ☐ Nov. ☐ Jan. ☐ Mar. ☐ Apr.

Your Name _____

Total # of guests _____ **Guest Name(s)** _____

Billing Address _____ **City, State, Zip** _____

Total owed *($30 per attendee, per meeting)* $_____

I intend to pay by (select one):

☐ ***CHECK*** (enclosed), *made payable to* **Blue Grass Dental Society**

Please mail check and registration forms to **BGDS, PO BOX 8928. Lexington, KY 40533**

☐ ***CREDIT CARD*** (details below)

Credit Card # _____ **Exp. Date**_____ **CVV** _____

Signature _____ **Date** _____

Registration forms should be completed and mailed to ***BGDS, PO Box 8928 Lexington, KY 40533***