

CDS Referral Network update

Patients visit the Chicago Dental Society website www.cds.org every day searching for dentists in their communities through our Find-A-Dentist Referral Network. You can help CDS stay current with the information we provide patients by logging on to the Members Section and updating your referral information. Or, if you prefer, complete the information requested below and **fax it to the Membership Department at 312.836.7317**.

Dentist name: _____ CDS Member number: _____

General Practitioner License number (CDS will not share this information.): _____

E-mail: _____ Website: _____
(Patients will be able to contact you directly, if you choose.)

Primary office address: _____

Primary office phone: _____ Primary office fax: _____
Days and hours primary office is open: _____

Second office address: _____

Second office phone: _____ Second office fax: _____
Days and hours second office is open: _____

Third office address: _____

Third office phone: _____ Third office fax: _____
Days and hours third office is open: _____

Dental degree: DDS DMD

Year of graduation: _____ Years in practice: _____ Dental school: _____

Advanced dental education:

Year of graduation: _____ Type of degree: _____ School/Program: _____

Year of graduation: _____ Type of degree: _____ School/Program: _____

Year of graduation: _____ Type of degree: _____ School/Program: _____

Year of graduation: _____ Type of degree: _____ School/Program: _____

Specialty degree:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Dental Public Health | <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Oral & Maxillofacial Pathology | <input type="checkbox"/> Prosthodontics |
| <input type="checkbox"/> Dentofacial Orthopedics | <input type="checkbox"/> Oral & Maxillofacial Radiology | <input type="checkbox"/> Orthodontics | |
| <input type="checkbox"/> Endodontics | <input type="checkbox"/> Oral & Maxillofacial Surgery | <input type="checkbox"/> Periodontics | |

Specialty License number (CDS will not share this information.): _____

Services offered by your practice:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Aesthetic Dentistry | <input type="checkbox"/> Halitosis | <input type="checkbox"/> Latex Free Office | <input type="checkbox"/> Sealants |
| <input type="checkbox"/> Air Abrasion | <input type="checkbox"/> Holistic Dentistry | <input type="checkbox"/> Microabrasion | <input type="checkbox"/> Sign Language for Hearing Impaired Patients |
| <input type="checkbox"/> Bonding/Cosmetic | <input type="checkbox"/> Home Care | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Teletypewriter for Hearing Impaired Patients |
| <input type="checkbox"/> Chronic Hepatitis B Patients | <input type="checkbox"/> Hospital Dental Care | <input type="checkbox"/> Nursing Home Residents | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Computer Enhanced Digital Imaging | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Oral Conscious Sedation | <input type="checkbox"/> Tooth Whitening |
| <input type="checkbox"/> Crown & Bridge | <input type="checkbox"/> Implants | <input type="checkbox"/> Oral Pap Tests | <input type="checkbox"/> Treat Afraid Patients |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Intraoral Camera | <input type="checkbox"/> Oral Pathology | <input type="checkbox"/> Ultrasonic Cleaning |
| <input type="checkbox"/> Emergency Services | <input type="checkbox"/> Invisalign | <input type="checkbox"/> Public Aid | <input type="checkbox"/> Wheelchair Accessible |
| <input type="checkbox"/> Forensics | <input type="checkbox"/> IV Sedation | <input type="checkbox"/> Reconstructive Services | |
| <input type="checkbox"/> General Anesthesia | <input type="checkbox"/> Lab on Premises | <input type="checkbox"/> Restorative | |
| | <input type="checkbox"/> Laser | <input type="checkbox"/> Root Canals | |

Member of Insurance Network (List all): _____

Languages spoken in practice: _____

I understand that the information I have provided will be made available to the public via the Chicago Dental Society (CDS) website. I give permission to use such information. I understand the listing is not a recommendation by CDS. I agree to hold harmless CDS against any and all liability, loss, damages, costs or expenses which CDS may hereafter incur, suffer or be required to pay by reason of use or misuse of my listing.

Signature: _____ Date: _____