LOS ANGELES SCHOOL OF DENTAL ASSISTING
2701 Beverly Boulevard
Los Angeles, CA 90057
(213) 389-6211 Office
(213) 389-4168 Fax

DENTAL ASSISTING CLASS REGISTRATION FORM (2024)

Date_____20_____

Name_____
(Please write your name the way you want it to appear in your certificate and transcript)

Social Security Number XXX-XX-_____Date of Birth_____

Current Address_____City_____State___Zip_____

Permanent Address_____City_____State___Zip_____

Home Phone (____)_____Work Phone (____)_____

Cell Phone (____)_____E-Mail_____

High School_____Year of Graduation_____

High School Address _____City_____State___Zip_____

Name of College or Technical Institution (If Any)_____

College Address_____Year of Graduation_____

How I heard about this program:_____

In Case of Emergency Contact:

Name_____Phone (____)_____Relationship_____

Address_____City_____State_____Zip_____

I wish to be considered for acceptance in the Dental Assisting Program:

Start Date:_____

I understand that the total cost of the course is $2,500.00 which includes a $400 non-refundable registration fee.