

## NOTICE OF ADDRESS CHANGE/ADDITIONAL LOCATION

Dentist name: \_\_\_\_\_ License number: \_\_\_\_\_

### Former Address:

Name of practice: \_\_\_\_\_

Office location: \_\_\_\_\_

\_\_\_\_\_  
(City, State, Zip code)

Mailing address (if different from office location): \_\_\_\_\_

\_\_\_\_\_  
(City, State, Zip code)

Telephone number: \_\_\_\_\_

This office was closed effective: \_\_\_\_\_

This mailing address is no longer in use as of: \_\_\_\_\_  
(date)

**Please check one:**       **New address**       **Additional location**

Name of practice: \_\_\_\_\_

Office location: \_\_\_\_\_

\_\_\_\_\_  
(City, State, Zip code)

Mailing address (if different from office location): \_\_\_\_\_

\_\_\_\_\_  
(City, State, Zip code)

Telephone number: \_\_\_\_\_

Effective date of new location: \_\_\_\_\_

Tax Id: \_\_\_\_\_

Check here if the above Tax Id has changed since your last update.

Name of owner \_\_\_\_\_

License number \_\_\_\_\_

Dentist's signature: \_\_\_\_\_

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

Please return this form by fax to (503) 243-3965