Bakersfield
DENTAL ASSISTING
ACADEMY

Registration Form

New Student

Please complete all fields to register for the Dental Assisting School Program.

Personal Information:

Full Name _____

Date of Birth (MM/DD/YYYY) _____

Gender Male ___ Female ___ Prefer not to say ___

Address _____

City _____

State _____

ZIP Code _____

Phone Number _____

Email Address _____

Education Background

High School Attended _____

Graduation Year _____

Other Post-Secondary Education _____

Degrees/Certificates Earned _____

Emergency Contact Information

Contact Name _____

Relationship _____

Phone Number _____

Email Address _____

Program Details:

Program Start Date _____

Have you previously attended a dental assisting program? Yes ___ No ___

If yes, please provide details: _____

Additional Information:

- What motivated you to pursue a career in dental assisting?

- How did you hear about our program?
  Online Search / Social Media / Friend / Family Other: _____

Declaration:

I hereby certify that the information provided in this application is true and complete to the best of my knowledge.

Signature: _____ Date: _____