



SHORT TERM ORTHO COURSE REGISTRATION FORM

NAME _____ AGE _____ GENDER _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

OFFICE PHONE _____ CELL _____

EMAIL ADDRESS _____

COURSE DATES THAT YOU ARE REGISTERING FOR _____

TOTAL COST FOR THIS COURSE IS __\$2250_____

CREDIT CARD INFORMATION: TYPE (MC or VISA) circle one
CC# _____ Name on card _____

EXPIRATION DATE _____ AUTHORIZATION # (on back of card) _____

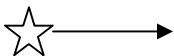
***YOUR CARD WILL BE BILLED FOR \$1000 AFTER YOUR REGISTRATION IS RECEIVED AND THE REMAINDER WILL BE BILLED WITHIN 2-3 DAYS OF THE ACTUAL COURSE DATE. THE \$1000 DOWNPAYMENT IS NON-REFUNDABLE AND LOCKS IN YOUR SPOT IN THE COURSE**

HOW DID YOU HEAR ABOUT **6-MONTH SMILES** COURSES? _____

DO YOU HAVE ANY **ORTHO EXPERIENCE**? Y or N? IF YES, WHAT IS YOUR EXPERIENCE?

ARE YOU THE TYPE OF LEARNER WHO LIKES TO BE **CLEARLY TOLD THE ANSWERS** TO YOUR QUESTIONS OR DO YOU **LIKE TO BE GUIDED** INTO FIGURING THE ANSWERS OUT FOR YOURSELF?

ARE THERE ANY SPECIFIC ASPECTS OF SHORT TERM ORTHO THAT YOU WOULD LIKE DR. SWAIN TO FOCUS ON IN YOUR COURSE? _____



YOU CAN PRINT OUT THIS REGISTRATION FORM AND FAX IT TO **585-594-0616**. (please email sixmonthsmiles@gmail.com also so we can be sure that we know the fax was sent)