

# DENTAL OFFICE NOTICE OF ADDRESS CHANGE

Dentist Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Former Address	
Office Location _____ _____	Mailing Address <i>(if different from office location)</i> _____ _____
Phone ( ) _____	Phone ( ) _____
This office was closed effective _____ (date)	This mailing address is no longer in use as of _____ (date)

Please check one:       **New Address**       **Additional Location**

Office Location	_____ _____
	Phone ( ) _____
Mailing Address <i>(if different from office location)</i>	_____ _____
	Phone ( ) _____
Taxpayer Identification Number (TIN):	_____
<input type="checkbox"/> Check here if the above TIN has changed since your last update.	
Are you the sole owner of this dental office?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are not the sole owner, please indicate the name and license number of each dentist with an ownership interest (whether as a proprietor, partner or shareholder). Use a separate sheet if there are more than two owners.	
Name of Owner _____	License Number _____
Name of Owner _____	License Number _____

Dentist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form to:

**Delta Dental of South Dakota**  
**PO Box 1157**  
**Pierre, SD 57501**

**OR Fax to: 605-224-0909**