Texas State Board of Dental Examiners

333 Guadalupe, Tower 3, Suite 800
Austin, Texas 78701-3942
(512) 463-6400 Fax (512) 649-1658

DENTAL ASSISTANT NAME CHANGE REQUEST FORM

Instructions: This form must be completely filled out. Submit this form along with your check or money order to the TSBDE address listed above. This form requires the legal documentation which reflects the name change (i.e., marriage license, divorce decree, court order, etc.). Please allow two weeks for processing. Check (✓) all permit(s) in which you are requesting.

☐ X-Ray $27 each	**How many?**	Amount	**Total Amount Due**

Social Security #:	Registration #:

Current Information

First Name	Middle Name	Last Name

New Information: This is how your name will be reflected on your certificate

First Name	Middle Name	Last Name

Current Address:	City	State	Zip
Permanent Address:	City	State	Zip:
Work Address:	City	State	Zip

Preferred mailing address: (preferred address will be made available to the public)
☐ Current ☐ Permanent ☐ Work

Daytime Phone #:	Email Address:

***Pursuant to Sec. 59.001 of the Dental Practice Act, the social security number of an applicant for or holder of a license, certificate of registration, or other legal authorization issued by a licensing agency to practice in a specific occupation or profession that is provided to the licensing agency is confidential and not subject to disclosure under Chapter 552, Government Code.**

I am also including a copy of the legal documentation (i.e., marriage license, divorce decree, court order) **required to make this name change and my non-refundable fee. ***

_____ _____

Signature **Date**