



## Texas State Board of Dental Examiners

1801 Congress Avenue, Suite 8.600  
 Austin, Texas 78701  
 (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.

<input type="checkbox"/> X-Ray \$27 each	How many?	Amount	<b>Total Amount Due</b>

Social Security #:	Registration #:
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**Current Information**

First Name	Middle Name	Last Name
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**New Information: This is how your name will be reflected on your certificate**

First Name	Middle Name	Last Name
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Current Address:	City	State	Zip
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Permanent Address:	City	State	Zip:
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Work Address:	City	State	Zip
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Preferred mailing address: (preferred address will be made available to the public)

Current
  Permanent
 Work

Daytime Phone #:	Email Address:
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\*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. \***

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**Signature**

\_\_\_\_\_

**Date**