

**2004 LIMITED LIABILITY COMPANY
ANNUAL REPORT**

FILED

Apr 30, 2004 08:00 AM
Secretary of State

DOCUMENT # L02000006325

1. Entity Name
PERFECT SMILE DENTISTRY, L.L.C.



Principal Place of Business
**12300 S. SHORE BLVD., STE. 208
MIZNER PLACE
WELLINGTON, FL 33414**

Mailing Address
**12300 S. SHORE BLVD., STE. 208
MIZNER PLACE
WELLINGTON, FL 33414**



03042004 No Chg-LLC

CR2E083 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number
04-3626811

Applied For
☐ Not Applicable

5. Certificate of Status Desired

☒ **\$5.00 Additional
Fee Required**

6. Name and Address of Current Registered Agent

**BATES, BARBARA
12300 S. SHORE BLVD., STE. 208
MIZNER PLACE
WELLINGTON, FL 33414**

**DO NOT WRITE
IN THIS SPACE**

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

**Filing Fee is \$50.00
Due by May 1, 2004**

000000145300
05/03/04-80019-008 55.00

9. MANAGING MEMBERS/MANAGERS

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP
**MGRM
BATES, BARBARA
12300 S. SHORE BLVD., STE. 208
WELLINGTON, FL 33414**

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP
**MGRM
AKEL, RASME
12300 S SHORE BLVD STE 208
WELLINGTON, FL 33414**

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

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TITLE
NAME
STREET ADDRESS
CITY - ST - ZIP

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IN THIS SPACE**

11. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my signature shall have the same legal effect as if made under oath, that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.

SIGNATURE: Barbara Akel DMD
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, OR AUTHORIZED REPRESENTATIVE

4-26-04
Date

(561) 204-4494
Daytime Phone #