

# 2000 UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Apr 27, 2000 8:00 am**  
**Secretary of State**

04-27-2000 90115 006 \*\*\*150.00

**DOCUMENT # V51290**

1. Entity Name

**ADVANCES IN DENTAL AESTHETICS, P.A.**

Principal Place of Business

Mailing Address

**2316 HILLCREST ST  
 ORLANDO FL 32803**

**2316 HILLCREST ST  
 ORLANDO FL 32803-4918**

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

4. FEI Number

**59-3143179**

Applied For

Not Applicable

Zip

Country

Zip

Country

5. Certificate of Status Desired

**\$8.75** Additional Fee Required



DO NOT WRITE IN THIS SPACE

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**SIMMS, DAVID M.-DMD  
 2316 HILLCREST ST  
 ORLANDO FL 32803**

Name

Street Address (P.O. Box Number is Not Acceptable)

City

**FL**

Zip Code

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.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

9. This corporation is eligible to satisfy its Intangible Tax filing requirement and elects to do so. (See criteria on back)

**FILE NOW!!! FEE IS \$150.00**  
**After MAY 1, 2000 Fee will be \$550.00**  
**Make Check Payable to Department of State**

10. Election Campaign Financing Trust Fund Contribution.

**\$5.00** May Be Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

| TITLE | NAME                | STREET ADDRESS     | CITY-ST-ZIP | <input type="checkbox"/> Delete |
|-------|---------------------|--------------------|-------------|---------------------------------|
| PD    | SIMMS, DAVID M. DMD | 2316 HILLCREST ST  | ORLANDO FL  | <input type="checkbox"/>        |
| S     | SIMMS, GAIL A.      | 2316 HILLCREST ST. | ORLANDO FL  | <input type="checkbox"/>        |
|       |                     |                    |             | <input type="checkbox"/>        |
|       |                     |                    |             | <input type="checkbox"/>        |
|       |                     |                    |             | <input type="checkbox"/>        |
|       |                     |                    |             | <input type="checkbox"/>        |

| TITLE | NAME | STREET ADDRESS | CITY-ST-ZIP | <input type="checkbox"/> Change | <input type="checkbox"/> Addition |
|-------|------|----------------|-------------|---------------------------------|-----------------------------------|
|       |      |                |             | <input type="checkbox"/>        | <input type="checkbox"/>          |
|       |      |                |             | <input type="checkbox"/>        | <input type="checkbox"/>          |
|       |      |                |             | <input type="checkbox"/>        | <input type="checkbox"/>          |
|       |      |                |             | <input type="checkbox"/>        | <input type="checkbox"/>          |
|       |      |                |             | <input type="checkbox"/>        | <input type="checkbox"/>          |

13. 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 or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

*David M. Simms, D.M.D.* 4/18/00 (407) 894-2691

CR2E034 (9/99)