



## Endodontic SucCEss for General Dentists 2-DAY HANDS-ON COURSE

Please write here the course date you are registering for: \_\_\_\_\_

### Registrant Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Website: \_\_\_\_\_

Private practice                       Corporate practice

Total years in practice: \_\_\_\_\_

Congratulations on taking time on investing in yourself and care for your patients. Thank you very much for choosing us. We would like to know you so that we can design our course specific to your needs.

1. Are you currently performing root canal treatment in your practice? Y / N  
If Yes answer the questions below.
2. If you use magnification, what do you use at present \_\_\_\_\_
3. Number of Root canal treatments done per week: \_\_\_\_\_
4. What instrumentation technique do you use? \_\_\_\_\_
5. What obturation technique do you use? \_\_\_\_\_
6. Have you used a cone beam CT before? Y / N
7. Do you do any re-treatment procedures? Y / N
8. Do you use ultrasonic instrumentation? Y / N

9. List 3 interests you have with regards to endodontics

- 1.
- 2.
- 3.

10. List 3 challenges you face while performing endodontic treatment:

- 1.
- 2.
- 3.

11. Please write down below any other expectations you have from the course.

We aim to do our best to focus on your requests.