T&S Therapy Centre INTERNATIONAL

TMJSTC INQUIRY APPLICATION

Date:				
Name:				
Phone Number:		Email Address:		
Number of years as a dentist:		Current Practice Location:		
Certifications:				
☐ Solo Practitioner ☐ Partner ☐ Associates If yes to Partner or Associates, please indicate how many:				
How many hygienists work in your practice?				
How many days per week do each work:				
Hygienist 1	Hygienist 2	Hygienist 3	Hygienist 4	Hygienist 5
How many patients do they see per day?				
How many hours do you practice per week?				
Why are you interested in becoming a TMJ & Sleep Therapy Centre?				
How many other dentists in your region market themselves for TMJ/Sleep Tx:				
Describe your experience in treating Craniofacial Pain / TMD and Sleep:				
What percentage of your practice is treating TMD, Craniofacial Pain/Sleep?				

Tel: 877.865.4325 | 619.462.0676 | Fax: 619.469.4524
Email: Education@TMJTherapyCentre.com | Web: www.TMJTherapyCentre.com

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What are your short term goals (1-3 years)?			
What are your long term goals (5+ years)?			
Desired TMJ Centre Region:			
Number of hours CE in Craniofacial/Orofacial Pain and Sleep:			
Annual income expectations	Year 1:	Years 2-3:	Year 5+
What is your current marketing budget?			
Equipment available:			

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