

YOUR DENTIST™ - STAGE 3 WEBSITE APPLICATION

Thank you for choosing to purchase a Your Dentist Stage 3 website. This Application Form requests basic information about your practice that will be used in the base set-up of your website. We encourage you to complete as much of this form as possible. Please note that once the base set-up is complete, you will be able to change anything you want as often as you want using your normal internet browser.

YOUR CONTACT INFORMATION			INFORMATION FOR WEBSITE				
Your Name:			Practice Name:				
Mailing Address:			Street Address (No PO Boxes please):				
Suburb:			State:	Postcode:	Suburb:	State:	Postcode:
Telephone: ()		Facsimile: ()	Telephone: ()		Facsimile: ()		
Your Personal Email Address:			Existing Practice Email Address:				

DOMAIN NAME

Please choose only ONE of the following options:

I already have a domain name:

www.

Please contact me so we can organise for this name to be delegated to the Your Dentist server for our new Stage 3 website.

Please register the following domain name on my behalf (please list a number of choices as not all names are available. Your Dentist will contact you prior to registering a name on your behalf to ensure you are happy with the names available.

1. **www.** _____
2. **www.** _____
3. **www.** _____

Your domain name can end in a number of suffixes including

- | | | |
|----------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> .com.au | <input type="checkbox"/> .net.au | <input type="checkbox"/> .id.au |
| <input type="checkbox"/> .com | <input type="checkbox"/> .net | <input type="checkbox"/> .org |
| <input type="checkbox"/> .info | <input type="checkbox"/> .biz | <input type="checkbox"/> .tv |

Reason for Registration

Please select the option which best describes the reason you have selected this Domain Name:

- I am applying for this Domain Name on the basis that it is connected to the name of my organisation or on the basis that the Domain Name is connected to my product, service, activity, event, venue or profession.
- I am applying for this Domain Name on the basis that it is connected to my Registered Business Name or Trademark.

PAYMENT INFORMATION

I enclose a cheque/money order to Your Dentist for \$999 or please charge my credit card as follows:

Main Street Publishing Pty Ltd

TAX INVOICE

ABN: 74 065 490 655

Type of Card: AMERICAN EXPRESS bankcard  MasterCard VISA Expiry Date: ___/___/___

Card Number: _____

Cardholder Name:Signature:Today's Date:

Please mail this form to: Your Dentist, PO Box 586, Cammeray NSW 2062
Or fax to (02) 9929-1999

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205 West Street, Crows Nest NSW 2065 • Australia • Tel: (02) 9929-1900 • mail: info@dentist.com.au

A sample website is located at www.dentist.com.au/stage3

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OPENING HOURS

Please list the opening and closing times of your practice and circle AM or PM. Cross out days that your practice is closed.

	Opening Time	Closing Time
Monday	: AM : PM	: AM : PM
Tuesday	: AM : PM	: AM : PM
Wednesday	: AM : PM	: AM : PM
Thursday	: AM : PM	: AM : PM
Friday	: AM : PM	: AM : PM
Saturday	: AM : PM	: AM : PM
Sunday	: AM : PM	: AM : PM

AFTER HOURS EMERGENCIES

Visitors to the website will be able to search for practices that offer a TRUE After Hours Emergency Service. PLEASE only complete this section if you really do offer an on call after hours service:

After Hours Emergency Telephone Number:

After Hours Emergency Procedure:

.....

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METHODS OF PAYMENT ACCEPTED

Please indicate the methods of payment accepted by your practice:

- | | |
|---|---|
| <input type="checkbox"/> Cash | <input type="checkbox"/> IBA Health |
| <input type="checkbox"/> Cheque | <input type="checkbox"/> Veterans Affairs |
| <input type="checkbox"/> American Express | <input type="checkbox"/> MBF Member Choice |
| <input type="checkbox"/> Bankcard | <input type="checkbox"/> Australian Patient Finance |
| <input type="checkbox"/> Diners Club | <input type="checkbox"/> CareCredit |
| <input type="checkbox"/> Mastercard | <input type="checkbox"/> Medichoice |
| <input type="checkbox"/> Visa | <input type="checkbox"/> Mediplan |
| <input type="checkbox"/> EFTPOS | <input type="checkbox"/> Other |
| <input type="checkbox"/> HICAPS | |

FINANCIAL POLICY

Please indicate your financial policy (such as payment required on the day, etc):

.....

EXACT LOCATION

Please describe the exact location of your practice and any special instructions that will help patients find where you are:

.....

.....

PARKING

Please detail if and where parking is available for your patients either at your practice, on the street or in a nearby car parking station:

.....

SERVICES OFFERED BY YOUR PRACTICE

Please give a detailed description of the services your practice offers:

.....

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TREATMENT OPTIONS

Please indicate if your practice offers the following treatment options:

- | | |
|--|--|
| <input type="checkbox"/> IV Sedation | <input type="checkbox"/> LaserBrite |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> BriteSmile |
| <input type="checkbox"/> General Anaesthesia | <input type="checkbox"/> Zoom! |
| <input type="checkbox"/> CEREC | <input type="checkbox"/> QuickSmile |
| <input type="checkbox"/> Air Abrasion | <input type="checkbox"/> Ozone Treatment |
| <input type="checkbox"/> Invisalign | <input type="checkbox"/> Laser - type..... |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Other..... |

DISABLED FACILITIES

Please indicate if your practice has facilities for the disabled:

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DENTISTS & HYGIENISTS WHO WORK AT YOUR PRACTICE

Please list all the Dentists, Hygienists and Therapists who work at your practice. Please photocopy this form if there are more than four.

Dentist Name:		
Registered Speciality (ie General Dentist, Orthodontist, Hygienist, etc):		
Gender: M / F	ADA Member: Yes / No	Year Reg'd: _ _ _ _
Languages Spoken:		
Personal Email Address: @		
Biographical Information/Qualifications (Attach a separate sheet if required):		

Dentist Name:		
Registered Speciality (ie General Dentist, Orthodontist, Hygienist, etc):		
Gender: M / F	ADA Member: Yes / No	Year Reg'd: _ _ _ _
Languages Spoken:		
Personal Email Address: @		
Biographical Information/Qualifications (Attach a separate sheet if required):		

Dentist Name:		
Registered Speciality (ie General Dentist, Orthodontist, Hygienist, etc):		
Gender: M / F	ADA Member: Yes / No	Year Reg'd: _ _ _ _
Languages Spoken:		
Personal Email Address: @		
Biographical Information/Qualifications (Attach a separate sheet if required):		

Dentist Name:		
Registered Speciality (ie General Dentist, Orthodontist, Hygienist, etc):		
Gender: M / F	ADA Member: Yes / No	Year Reg'd: _ _ _ _
Languages Spoken:		
Personal Email Address: @		
Biographical Information/Qualifications (Attach a separate sheet if required):		

YOUR TEAM

Please give details of the practice manager, dental assistants, business staff and other non-registered personnel.

Name:
Title (ie Clinical assistant, patient coordinator, etc):
Biographical Information/Qualifications (Attach a separate sheet if required):

Name:
Title (ie Clinical assistant, patient coordinator, etc):
Biographical Information/Qualifications (Attach a separate sheet if required):

Name:
Title (ie Clinical assistant, patient coordinator, etc):
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