gcdl™ complete dental solutions

New Client Form

224-676-1303
info@gcdl.net
www.gcdl.net

DOCTOR/OFFICE INFORMATION

Office/Doctor Name _____

Address _____

City/State/Zip _____

Phone _____ Alt. Phone _____

Email _____

OFFICE MANAGER INFORMATION

First Name _____

Last Name _____

Cell Phone _____

Work Phone _____

Email _____

Referred by _____

BILLING CONTACT

First Name _____

Last Name _____

Cell Phone _____

Work Phone _____

Email _____

PROVIDERS FOR LOCATION

Doctor #1 _____ Email _____ Tel _____

Doctor #2 _____ Email _____ Tel _____

Doctor #3 _____ Email _____ Tel _____

Doctor #4 _____ Email _____ Tel _____

Doctor #5 _____ Email _____ Tel _____

PLEASE CHECK ALL THE ITEMS THAT APPLY

Send Starter Kit? ☐ Schedule a Pick-Up? ☐ Do you want Portal Access? ☐ Paper Statements? ☐

Schedule a Meeting? ☐ Previous Client? ☐ Would you like our Newsletter? ☐ Paperless Statements? ☐

Need Pricelist? ☐ Have Oral Scanner? ☐ Autopay? ☐ Yes ☐ No Both Statements? ☐

Additional Notes:

FOR INTERNAL USE ONLY. PLEASE DO NOT WRITE IN THIS AREA.

Submit Form

_____ Information Taken by

_____ Date