3107 Lone Tree Way, Suite A
Antioch Ca 94509
hello@gooddaydentistry.com

Welcome! Where it's always a Good Day at the dentist!

We are pleased that you've chosen us to provide your dental care. We appreciate the trust that you have placed in us, and we strive to provide the exceptional dental care that you expect. We know that the most important asset of our practice is you, and we hold your comfort and care to the highest concern. Finding a dentist is an important decision, and we want to thank you for choosing our dental practice.

We are grateful to have you as part of our dental family where we will do our very best to exceed your expectations and always make sure it's a good day at the dentist. If you have any questions, please feel free to discuss them with our doctor and staff.

Thank you again for choosing us to serve your dental needs. We look forward to a lifetime of continuing care for you and your family.

GOOD DAY DENTISTRY

Photograph and/or Video Consent and Release Form

I, (patient name) _____(date of birth)_____ hereby authorize

DR. Elmirra Dayrit and associates to take photographs and/or videos of me, my face, jaw and teeth, before, during and after treatment. Such photographs and/or videos, may include me, and my entire face/mouth.

I consent to allow the photographs and/or videos to be used for the following purposes (check all that apply):

☐ Dental records, dental research, dental education (including without limitation: lectures, seminars, demonstrations, professional publications, educational videos, etc).

☐ Social media (including without limitation: Facebook, Instagram, Twitter, TikTok, Google, Yelp, etc), marketing material (including without limitation: websites and printed materials, for the purposes of patient education and/or promotional marketing, etc).

☐ I decline to consent.

☐ I further understand that if the photographs and/or videos are used, my name and/or other identifying information will be kept confidential to the extent of practicable (other than if full face photographs and/or videos are used).

- I hereby grant, DR. Elmirra Dayrit and any of its assigns and licenses all rights to exhibit this work in print and electronic form, publicly or privately, and to distribute and/or market without limitation. I waive any and all rights, claims, or interests I may have to control the use of my identity or likeness in whatever media may be used. There is no time limit on the validity of this release, nor is there any geographic limitation on where these materials may be distributed. I do not expect compensation, financial or otherwise, for the use of these photographs and/or videos.

_____ _____ _____

Printed name of patient/legal representative **Signature** of patient/legal representative **Date**

_____ _____

Witness Signature **Date**

GOOD DAY DENTISTRY

APPOINTMENT SCHEDULING POLICY

In order to accomplish quality treatment and to have fair time share with your fellow patients, we would appreciate your understanding of the following:

1. Missed appointments will be subject to a fee of $75 if notice was not received within 48 hours of your scheduled appointment.

2. Patients arriving 15 minutes or more past the scheduled appointment time will need to reschedule their appointment.

3. Our office staff will give you two courtesy reminders, 1 week and 1 day, before your appointment.

   However, we strongly recommend that you keep track of your appointments, in case you do not receive the reminder.

Signature of Patient / Responsible Party:_____

Date: _____

GOOD DAY DENTISTRY

Financial Policy

We appreciate your selection of this office to serve your dental needs. Our goal is to provide the best possible care for our patients to extend comprehensive care and avoid misunderstandings. We have provided a list of our payment options.

Preventive, Basic and Major Treatment

Payment is due the day of service.

Payment Options

We offer a Senior Citizen Discount of 10% for patients age 60 and over.
We offer an in house savings plan, PDP (Premier Dental Plan), that covers 2 exams, 2 cleanings or Perio maintenance, 2 sets of x-rays and includes 25% off dental treatment.
Ask our front desk for more information.

Insurance

We will estimate your dental insurance benefits to the best of our knowledge. As a courtesy, we will bill your insurance for you. We allow 60 days for your insurance company to pay your claim. If insurance pays less than anticipated and does not cover the estimated cost, the balance becomes the patient's responsibility.

When you receive treatment in our office you agree to be financially responsible for the entire fee.

Signature:_____ Date:_____