



# Valley Pediatric Dentistry

**Jothi Bains, DDS**

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

Date of birth: \_\_\_\_\_

Parent name: \_\_\_\_\_

Parent phone number: \_\_\_\_\_

**Please email radiographs to [office@valleykidsdds.com](mailto:office@valleykidsdds.com)**

Referring office info

Office name: \_\_\_\_\_

Doctor name: \_\_\_\_\_

Office phone number: \_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Thank you for trusting us with your patient's care!**