



First Smiles
Children's Dentistry

Dr. Jothi Bains DDS

Pediatric Specialist

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Email: office@1stSmiles.com

Date: _____

Appointment Date/Time Given: _____

Patient Name: _____

Age: _____ DOB: _____ Phone Number: _____

Parent/Guardian Name: _____

X-Rays Available: Yes - Date: _____ No

_____ E-mail to your office

_____ Mail to your office

_____ Sent with patient

Date of last Prophylaxis: _____

Reason for referral: _____

Referring Dr: _____

Contact Phone Number: _____

*Please note: Specialists carry their own fee schedule and insurance contract affiliations. Please contact their office for more information.