

Austin Endodontics, L.L.P.
Practice Limited to Endodontics

Michael B. Doughty D.M.D.
Erik J. Galian D.M.D.

Robert R. Galvan Jr., D.D.S.
Deepika L. Ganne, D.D.S.

Name _____
Last First Middle Name of Spouse/Guardian

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Cellular () _____

Date of Birth _____ Sex _____ SS# _____

Employer _____ Occupation _____ Email _____

General Dentist _____ Referred by: _____

Physician's Name _____ Physician's Phone _____

In Case of Emergency, notify: _____
Name Relationship Phone #

- Are you in good health? Yes No
- Has there been any change in your health within the past year? Yes No
- Are you under the care of a physician? Yes No
- Have you ever had any serious illness, operation, or hospitalization?..... Yes No
 - If so, explain and give dates _____
- Have you had abnormal bleeding with previous extractions, surgery, or trauma?..... Yes No
- Have you had surgery or x-ray treatments for a tumor, growth, or head and neck condition? Yes No
- Have you had any serious trouble associated with previous treatment? Yes No
- Do you have any disease, condition, or problem that you think we should know about? Yes No
 - If so, please explain _____
- Are you taking any medications or drugs?..... Yes No
 - If so, please list _____
- For women, Are you currently pregnant or do you think you may be pregnant?..... Yes No
 - If so, what is your approximate due date? _____

(Please See Reverse)

- Are you allergic or have you reacted adversely to:
 - Local anesthetics Yes No
 - Antibiotics, if so, which one? Yes No
 - Aspirin Yes No
 - Iodine Yes No
 - Codeine or other Narcotics Yes No
 - Other _____ Yes No

- Do you have or have you had any of the following diseases or problems?
 - Rheumatic fever or Rheumatic Heart Disease Yes No
 - Mitral Valve Prolapse or Heart Murmurs Yes No
 - Congenital Heart Lesions Yes No
 - Has your physician requested that you premedicate with antibiotics prior to dental appointments for a heart condition or joint replacement? Yes No
 - Cardiovascular Disease Yes No
(Heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
 - Do your ankles swell? Yes No
 - Do you have pain in your chest upon exertion? Yes No
 - Do you have a cardiac pacemaker? Yes No
 - Sinus trouble Yes No
 - Asthma Yes No
If yes, do you use an inhaler or nebulizer? Yes No
 - Hay Fever Yes No
 - Hives or Skin Rash Yes No
 - Fainting Spells or Seizures Yes No
 - Epilepsy Yes No
 - Diabetes Yes No
 - Hepatitis, Jaundice, or Liver Disease Yes No
 - Arthritis Yes No
 - Fluid Retention Yes No
 - Stomach Ulcers Yes No
 - Kidney Trouble Yes No
 - Tuberculosis Yes No
 - Thyroid Disease Yes No
 - Sexually Transmitted Disease Yes No
 - HIV or AIDS Yes No
 - Blood Disorders (anemia) Yes No
 - Substance Abuse Yes No

Other _____

Comments: _____

Permission for Endodontic Procedures:

I hereby certify that the above information is correct to the best of my knowledge, and upon acceptance, give consent to perform the necessary treatment needed after examination and consultation, on me or my child. I understand that only root canal treatment is performed at this office. The permanent restoration (cap, crown, filling, etc.) will be performed by my general dentist after the root canal.

Signature _____ Date _____