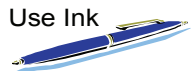




PATIENT MEDICAL HISTORY



- Amalgam
- Anterior Composite
- Posterior Composite
- Cast Gold
- Periodontal Treatment

PATIENT'S FIRST NAME: _____ CANDIDATE I.D. #: _____

DATE OF EXAMINATION: _____ EXAM SITE: _____

Instructions to the Patient: Have you had or have you ever experienced any of the following conditions? Circle "YES" or "NO" to all questions.

- | | | | | | |
|---|------------|-----------|-------------------------------|------------|-----------|
| A Heart Condition | YES | NO | H Diabetes | YES | NO |
| B Heart Surgery | YES | NO | I Tuberculosis | YES | NO |
| C Valve Replacement | YES | NO | J Kidney/Renal Disease | YES | NO |
| D Stroke | YES | NO | K Hepatitis/Jaundice | YES | NO |
| E High Blood Pressure | YES | NO | L HIV Positive | YES | NO |
| F Bleeding Disorder | YES | NO | M Epilepsy/Seizures | YES | NO |
| G Asthma/Lung/Respiratory Condition(s) | YES | NO | N Joint Replacement | YES | NO |

Answer the following questions as completely and accurately as possible:

1. Are you taking any medication, pills or drugs (prescribed or not)? **YES** **NO**
If yes, please list: _____
2. Do you have a sensitivity or allergy to latex? **YES** **NO**
If yes, please list: _____
3. Are you allergic to any medicines? **YES** **NO**
If yes, please list: _____
4. Have you ever received intravenous bisphosphonates for bone cancer or severe osteoporosis? **YES** **NO**
If yes, please list: _____
5. Are you under the care of a physician at the present time or have you been treated by a physician in the past six months? If yes, for what condition? **YES** **NO**

6. Do you have any disease or condition not listed above that we should know about? **YES** **NO**
If yes, please list: _____
7. Women only: Are you pregnant? **YES** **NO**
If yes, expected due date: _____

Patient's Initials: _____

Instructions to Candidate:

Circle any "YES" answers in red. State in the lines below the significance (if any) and the steps taken for any alteration of procedure for this exam. Indicate the need and use for premedication, if necessary. Record all medication taken today on the back of the procedure worksheet. Attach any verification of the patient's medical acceptability. A Floor Examiner must initial this form prior to "patient check-in" if any "YES" has been circled. If no "YES" has been circled, send this form with the patient for check-in.

Patient Blood Pressure

Patient Pulse

Floor Examiner Initials
(If any "YES" answers)

Consent Form on Reverse

PATIENT CONSENT FORM AND ASSUMPTION OF RISK

Western Regional Examining Board, an Arizona non-profit corporation ("WREB") is a national dental and dental hygiene testing agency required to test candidates' clinical skills for the states that accept the results of WREB exams. This involves doing certain types of dental procedures for volunteer patients. You have agreed to volunteer as a patient for a candidate (the "Candidate") that is taking a WREB exam.

The WREB examinations are typically administered at various dental schools and universities ("School" or "Schools") around the country. Other than administering an examination at a School, WREB has no relationship or affiliation with any of the Schools.

The Candidate has met the educational requirements necessary to take the exam, but WREB has no knowledge regarding the Candidate's skill or competence. The Candidate who is treating you may not be licensed in any of the member states of WREB. The Candidate is performing the procedure(s) listed below for you as a part of the exam to determine if he is qualified to be licensed as a dentist or dental hygienist in a WREB state.

WREB does not assume any responsibility for the treatment you receive from the Candidate. If an injury occurs during the exam, neither WREB (including its examiners) nor the School assumes any responsibility to provide follow up dental treatment. WREB assumes no responsibility to notify you of any poor, substandard, or negligent work rendered by the Candidate. If you have any concerns regarding the quality of care administered by the Candidate, then you should see a licensed dentist.

You hereby expressly agree to assume the risk for injuries of any kind that occur before, during, or after the WREB examination. You agree to indemnify WREB (including its examiners) against and hold WREB and its examiners harmless from any and all losses, claims, demands, damages, assessments, costs and expenses (including reasonable attorneys' fees) of every kind, nature or description resulting from, arising out of or relating to your health care or condition before, during, or after the examination.

I hereby state that I have read and understand this Patient Consent Form and Assumption of Risk. I confirm that I have not completed more than two years of dental school, foreign or domestic. I consent to having radiographs and a dental examination made for me. I hereby consent to the procedure(s) listed below. I realize that local anesthetics may have to be administered and I consent to the use of local anesthetics by the Candidate. I consent to having the WREB examiners take intraoral photographs of my teeth and gums for use in future examiner calibrations, provided my name is not associated with the photographs in any way. I understand that my medical history on the reverse side will be shared with examiners as required to determine eligibility for the exam and for reference in case of medical emergency.

I authorize Candidate ID #: _____, and his or her assistant, to perform upon myself the following:

Dental Procedure(s): _____

Signature: _____

Printed Name: _____

Address: _____

_____ Zip: _____

**Parent or Guardian's Signature
(if patient is a minor)**

**Must be at least 18 years of age
for Periodontal Treatment**