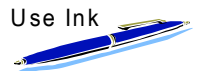




PATIENT MEDICAL HISTORY



- 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 (e.g. Zometa, Aredia) 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)

PATIENT CONSENT FORM

Disclosure statement and express assumption of risk for any damage from (1) exposure to blood borne infectious agents such as HIV, Hepatitis, and other microorganisms in the blood, (2) exposure to oral or respiratory secretions, (3) anesthesia reaction, (4) paraesthesia, and (5) other dental injuries.

WREB is a national dental and dental hygiene testing agency required to test Candidates' clinical skills for the states subscribing to our service. This involves doing certain types of dental procedures on volunteer patients.

The Candidate who is treating you may not be licensed in any of the member states of WREB. The Candidate has met the educational requirements necessary to be admitted to the exam, but neither WREB, nor its Examiners, nor other WREB personnel have any knowledge of the Candidate's skill or competence. The Candidate is performing this procedure as a part of the exam to determine qualification for licensure.

WREB cannot, and therefore, does not assume any responsibility or liability for the treatment you receive during the course of the exam, or for any of the acts, omissions or negligence committed by any such Candidate. Also, WREB assumes no duty or responsibility to notify any patient of poor work done by any Candidate. It is recommended that you see a licensed dentist if you have concerns regarding the quality of care received.

WREB and the school cannot, and therefore, do not assume any responsibility or liability for the health status of you or the Candidate. If an exposure or other injury occurs during the course of this exam, neither WREB nor the school assumes any duty or responsibility to you to provide serologic testing, counseling, follow up, or any other health service.

LIMITATION OF LIABILITY AND INDEMNITY AGREEMENT

I, the undersigned, state that I have read and understood the above disclosure statement and express assumption of risk. The nature and purpose of this procedure as well as any risks or complications have been explained to me. I understand that WREB is not responsible for acts of negligence committed by any Candidate during the course of the exam, and no representations or statements have been made by WREB to me about the skill or competence of any Candidate, or the result of any treatment I receive. I agree that WREB and the school are not responsible for the prevention or management of any of the above listed incidents. I agree to release and discharge WREB and the school from any liability or damage which may occur to me unless expressly committed by WREB or school personnel. I understand that WREB and the school have no responsibility or duty to provide medical evaluation, treatment, counseling, follow up, or any type of compensation for any of the above listed incidents. I further understand that WREB has no responsibility or duty to notify or inform me of any faulty work done by the Candidate.

I confirm that I have not completed more than two (2) years of dental school.

I CONSENT to having radiographs and dental examination made on me and the specific procedures listed below. I realize that anesthetics may have to be administered and I CONSENT to the use of anesthetics by the Candidate or other qualified practitioner. I CONSENT to having the WREB Examiners or school personnel take photographs of my teeth and gums for use in future Examiner calibrations, provided my name is not in any way associated with said photographs. I understand that the 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**