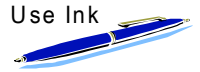




LOCAL ANESTHESIA
PATIENT MEDICAL HISTORY



CANDIDATE # _____

PATIENT'S FIRST NAME _____

DATE _____

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 known latex allergy or sensitivity to latex? YES NO
If yes, please list: _____
3. Are you allergic to any medicines? YES NO
If yes, please list: _____
4. Are you receiving or 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? YES NO
If yes, for what condition: _____
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 examination. Indicate the need and use for antibiotic prophylaxis, if necessary. Attach any verification of the patient's medical acceptability.

PATIENT BLOOD PRESSURE _____

PATIENT PULSE _____

CHIEF EXAMINER INITIALS _____

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 or dental hygiene 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/she 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 or exposure to infectious agents occurs during the exam, neither WREB nor the School assumes any responsibility to provide follow up care. WREB assumes no responsibility to notify you of any poor, substandard, or negligent work rendered by the Candidate.

You hereby expressly agree to assume the risk for an exposure or injuries of any kind that occur before, during, or after the WREB examination. You agree to indemnify WREB against and hold WREB 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 am 18 years of age or older. I hereby consent to the procedure(s) listed below. 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 # _____, to perform local anesthesia injections upon myself.

Signature: _____

Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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