Circle “YES” or “NO” to all questions. “YES” responses must be circled in red.

Do you have or have had any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Response</th>
<th></th>
<th></th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Heart Condition(s)</td>
<td>YES</td>
<td>NO</td>
<td>I</td>
<td>Tuberculosis</td>
<td>YES</td>
</tr>
<tr>
<td>B</td>
<td>Heart Surgery</td>
<td>YES</td>
<td>NO</td>
<td>J</td>
<td>Kidney/Renal Disease</td>
<td>NO</td>
</tr>
<tr>
<td>C</td>
<td>Valve Replacement</td>
<td>YES</td>
<td>NO</td>
<td>K</td>
<td>Hepatitis/Jaundice</td>
<td>NO</td>
</tr>
<tr>
<td>D</td>
<td>Stroke</td>
<td>YES</td>
<td>NO</td>
<td>L</td>
<td>HIV Positive</td>
<td>NO</td>
</tr>
<tr>
<td>E</td>
<td>High Blood Pressure</td>
<td>YES</td>
<td>NO</td>
<td>M</td>
<td>Epilepsy/Seizures</td>
<td>NO</td>
</tr>
<tr>
<td>F</td>
<td>Bleeding Disorder(s)</td>
<td>YES</td>
<td>NO</td>
<td>N</td>
<td>Joint Replacement</td>
<td>NO</td>
</tr>
<tr>
<td>G</td>
<td>Respiratory Condition(s)</td>
<td>YES</td>
<td>NO</td>
<td>O</td>
<td>Liver/Hepatic Disease</td>
<td>NO</td>
</tr>
<tr>
<td>H</td>
<td>Diabetes</td>
<td>YES</td>
<td>NO</td>
<td>P</td>
<td>Latex Allergy/Sensitivity</td>
<td>NO</td>
</tr>
</tbody>
</table>

Answer the following questions as completely and accurately as possible:

1. Do you have any known allergies or sensitivities (food, medications, dental material)?
   - YES NO
   - If yes, please explain:_____________________________________________________________________

2. Are you taking any prescribed medications?
   - YES NO
   - If yes, please explain:_____________________________________________________________________

3. Are you taking any Over the Counter (OTC) supplements or medications?
   - YES NO
   - If yes, please explain:_____________________________________________________________________

4. Are you currently receiving or have received intravenous bisphosphonate therapy?
   - YES NO
   - If yes, please explain:_____________________________________________________________________

5. Within the last six months, have you been seen by, or are you currently under the care of a physician or health care provider?
   - YES NO
   - If yes, please explain:_____________________________________________________________________

6. Have you experienced local anesthetic complications with dental treatment in the past?
   - YES NO
   - If so, please explain:_____________________________________________________________________

7. Have you used any recreational drug(s) (cocaine or methamphetamines) within the last twenty-four hours?
   - YES NO
   - If yes, please explain:_____________________________________________________________________

8. Do you have or have you been exposed to any condition (disease) not listed above?
   - YES NO
   - If yes, please explain:_____________________________________________________________________

9. Women: Are you pregnant?
   - YES NO
   - If yes, expected due date:______________________________________________________________

INSTRUCTIONS TO CANDIDATE

Please state below the reason for any alteration in standard treatment. Attach verification of the patient’s medical clearance for dental hygiene/anesthesia procedures or state the reason for necessary antibiotic coverage.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Patient’s Initials________
PATIENT CONSENT 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 examinations. This involves doing certain types of dental procedures for volunteer patients.

The WREB examinations are typically administered at various dental or dental hygiene schools and universities ("School" or "Schools") around the country. You have agreed to volunteer as a patient for a candidate (the "Candidate") that is taking a WREB examination. 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 and the Schools have 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 will be performing a dental examination on you, including one or more procedures (collectively, the “Procedures”) as a part of the examination to determine if the Candidate is qualified to be licensed as a dentist or dental hygienist in a WREB state.

WREB and the Schools do not assume any responsibility for the treatment or Procedures you receive from the Candidate. If an injury occurs during the examination, neither WREB (including its examiners) nor the School (Including anyone acting on its behalf) assumes any responsibility to provide follow up dental treatment. WREB and the Schools assume no responsibility for notifying 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.

By volunteering to be a patient for the Candidate during the WREB examination, you expressly acknowledge and agree that you are not and will not become a patient of record of the School solely due to the treatment or Procedures that you receive from the WREB Candidate during the examination. The School is merely a hosting site and is in no way responsible for supervising or overseeing the dental services provided by the WREB Candidate during the examination.

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) and the School (including anyone acting on its behalf) against, and hold WREB (including its examiners) and the School (including anyone acting on its behalf) 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). I realize that local anesthetics may have to be administered and I consent to the use of local anesthetics by the Candidate. I understand that my medical history, on the reverse side of this form, 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 me.

Signature: ___________________________________ Date _________________________

Printed Name: ___________________________________ Parent or Guardian’s Signature

Address: ___________________________________ (if patient is a minor)

City: _____________ State: _____ Zip: __________