Circle "YES" or "NO" to all questions. "YES" responses must be circled in red.
Do you have or have had any of the following?

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

Answer the following questions as completely and accurately as possible:

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

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

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

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

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?
   If yes, please explain:
   YES NO

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

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

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

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

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________
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 attorney’s 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 not a dentist or dental hygienist foreign or domestic. I consent to having radiographs and a dental examination made for me. I 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 consent to having WREB examiners take intraoral photographs of my teeth and gums for the 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 # _______________ to perform a dental hygiene examination (including the Procedures) upon me.

Signature: ___________________________________________ Date: ________________

Printed Name: ___________________________________________ Parent or Guardian’s Signature

Address: _______________________________________________ (if patient is a minor)

City: ________________ State: _____ Zip: __________

Must be at least 18 years of age for Periodontal Treatment

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