

PATIENT MEDICAL HISTORY

- Posterior Composite 1 Amalgam
- Posterior Composite 2 Cast Gold
- Anterior Composite Periodontal Treatment

PATIENT'S FIRST NAME: _____

CANDIDATE ID#: _____

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? **YES NO**
If yes, for what condition: _____
6. Do you have, or have you been exposed to, 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 "YES" answers. 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 the administration of local anesthetic and before the patient is sent to the grading area for "patient check-in."

Patient Blood Pressure

Patient Pulse

Floor 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 examinations. This involves doing certain types of dental procedures for volunteer patients.

The WREB examinations are typically administered at various dental 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 skills 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 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 Procedures. 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 a dental examination, (including the procedures), upon me.

Dental Procedure(s): _____

Printed Name: _____

Phone: _____

Address: _____

_____ Zip: _____

Patient Signature (or Parent/Guardian if patient is a minor)
Must be at least 18 year of age for Periodontal Treatment