CDCA WREB CITA

LOCAL ANESTHESIA PATIENT MEDICAL HISTORY

CANDIDATE ID LABEL

PATIENT FIRST NAME_____ **DOB**_____

Do you have or have had any of the following? Response required. Circle all "YES" responses in RED.

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

Answer the following questions regarding your health; explain any "yes" responses.

1. Do you have any known allergies or sensitivities (food, medications, dental material)? ***YES*** ***NO***
   Comment:_____
2. Are you taking any prescribed medications? ***YES*** ***NO***
   Comment:_____
3. Are you taking any Over the Counter (OTC) supplements or medications? ***YES*** ***NO***
   Comment:_____
4. Are you currently receiving or have you previously received intravenous bisphosphonate therapy? ***YES*** ***NO***
   Comment:_____
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***
   Comment:_____
6. Have you experienced local anesthetic complications with dental treatment in the past? ***YES*** ***NO***
   Comment:_____
7. Have you used any recreational drug(s) (cocaine or methamphetamines) within the last 24 hours? ***YES*** ***NO***
   Comment:_____
8. Do you have or have your been exposed to any condition (disease) not listed above? ***YES*** ***NO***
   Comment:_____
9. **Women:** Are you pregnant? ***YES*** ***NO***
   Expected due date (MM/DD/YY):_____

CANDIDATE: State reason for any alteration in standard treatment. Attach verification of patient's medical clearance for anesthesia procedures or state reason for necessary antibiotic coverage. _____

_____

_____

_____

Patient Blood Pressure	Pulse Rate	Time Taken	Chief Initials
1)			
2)			
3)			

Medical History Attestation:

Patient Initials_____

Medical History Reviewed:

Chief Examiner Initials_____

(Consent Form - Next Page)

PATIENT CONSENT AND ASSUMPTION OF RISK

CDCA-WREB-CITA, a non-profit corporation is a national dental and dental hygiene testing agency required to test candidates' clinical skills for the states that accept the results of CDCA-WREB-CITA examinations. This involves doing certain types of dental procedures for volunteer patients.

The CDCA-WREB-CITA 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 (the "Patient") for a candidate (the "Candidate") that is taking a CDCA-WREB-CITA examination. Other than administering an examination at a School, CDCA-WREB-CITA has no relationship or affiliation with any of the Schools.

The Candidate has met the educational requirements necessary to take the exam, but CDCA-WREB-CITA 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 CDCA-WREB-CITA. 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 CDCA-WREB-CITA state.

CDCA-WREB-CITA 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 CDCA-WREB-CITA (including its examiners) nor the School (Including anyone acting on its behalf) assumes any responsibility to provide follow up dental treatment. CDCA-WREB-CITA 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 CDCA-WREB-CITA 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 CDCA-WREB-CITA 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 CDCA-WREB-CITA Candidate during the examination.

You hereby expressly agree to assume the risk for injuries of any kind that occur before, during, or after the CDCA-WREB-CITA examination. You agree to indemnify CDCA-WREB-CITA (including its examiners) and the School (including anyone acting on its behalf) against, and hold CDCA-WREB-CITA (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, as the Patient, 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, and consent 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 will be shared with examiners as required to determine eligibility for the exam and for reference in case of medical emergency.

I, as the Patient, authorize Candidate ID # _____ to perform local anesthesia injections upon me.

Signature:_____ Date: _____

Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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