Dr. Will Ellingson, DMD

1030 S. 11400 S. Suite 2

Sandy, Utah 84094

801-255-2100

GRANITE VIEW DENTAL

Consent To Proceed

I authorize Dr. William Ellingson D.M.D. and or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic or surgical treatments.

I certify that the answers to the health or the dental health questions are accurate and correct to the best of my knowledge. Since a change of medication can affect dental treatment, I understand the importance and agree to notify the dentist of any changes at any subsequent appointment.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as a part of the dental treatment, including preventative procedures such as cleanings, and basic dentistry including fillings of all types, teeth may be sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including but not limited to crowns, small dental instruments, drill components, etc., may be aspired (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____

(patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____