# Mission Hill Dental

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## AUTHORIZATION FOR DENTAL TREATMENT OF MINORS

| Name of Minor(s) | DOB | Allergies/Special Conditions |
|---|---|---|
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I/We, being the parent(s) or legal guardian(s) of the above named minors(s), do hereby:

____________Authorize patient to obtain treatment unaccompanied by an adult

Parent Name:_____________________________________Date:_________________________

Signature of Parent/Guardian:__________________________________________________