



Hilltop Dental Associates, P.C.

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Gary A. Minchau, D.M.D.

Matthew R. Sroka, D.M.D.

Parental Consent for Minors

Name of Patient: _____

Name of Parent/Guardian: _____

I, _____, hereby authorize Dr. Gary Minchau, Dr. Matthew Sroka and all licensed staff of Hilltop Dental Associates to perform _____ for my child, _____.

Signature of Parent/Guardian _____ Date _____