



# DENTAL ASSOCIATES PA

Klockner Road Office 2929 Klockner Road Hamilton Square, NJ 08690 Phone (609) 586-6603 Fax (609) 586-1801

## Limited Power of Attorney to Exercise Consent for Treatment of a Minor at Hamilton Dental Associates

I \_\_\_\_\_  
Name and Relationship

Hereby give limited power of attorney for \_\_\_\_\_  
to consent to dental treatment and any medical emergency care on my behalf for my  
child/children  
\_\_\_\_\_  
Name/Names

This limited power of attorney vests all rights and authority to legally consent to such treatment in my absence and shall be effective from the date of the document until I notify Hamilton Dental Associates of my decision to revoke such rights and authority.

Signature \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_