



ALTA DENTAL GROUP

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LEONIDES SANDOVAL, D.D.S., P.A.  
813 DOUGLAS AVE., SUITE 5  
ALTAMONTE SPRINGS, FL 32714  
TELEPHONE: (407) 774-9872  
WWW.ALTADENTAL.COM

Yo entiendo que **SI NO ASISTO (FALLO), CANCELO, O CAMBIO** mi cita dental **SIN 24 HORAS** de anticipacion, sere resonsable por el cargo de **\$75.00**.

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Nombre del Paciente

\_\_\_\_\_  
Firma del Paciente

\_\_\_\_\_  
Fecha



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I understand that if I **FAIL, RESCHEDULE, OR CANCEL MY APPOINTMENT** with 24hours notice, I will be responsible for a charge of \$75.00.

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Patient Signature

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Date

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Print Name