Arkansas State Dental Association
7480 Highway 107
Sherwood, AR 72120
Phone: (501) 834-7650 Fax: (501) 834-7657

Patient Request for Mediation

CONFIDENTIAL

Upon receipt of this completed form, a mediator will be assigned and will contact you within sixty (60) days to discuss your request and help resolve the issue. While a refund of the charges you have paid is one of the options that may be recommended by the mediator, **a request for refund should not be made in writing on this form.**

Please type or print legibly

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip:-_____

Day Phone: _____ Evening Phone: _____

Treating Dentist

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Date of Last Appointment:_____

Describe the problem(s) specific to the dental treatment received. Use the back or attach pages in necessary. A copy of this statement will be provided to the treating dentist.

_____
_____
_____
_____
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_____

In order that a complete review be performed, I authorize the release to the peer review committee any dental records or information by anyone who has examined me previously. I further give permission for the committee to perform a clinical examination, if necessary.

Patient's Signature (or parent/guardian, if minor):_____

Date:_____

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