

**Arkansas State Dental Association  
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: \_\_\_\_\_

