Montana 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:_____

Phone:_____Date of Last Appointment: _____

Describe the problem(s) specific to the dental treatment received. Use the back or attach pages if 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 of any dental records or information by anyone who has examined me previously. I further give my permission for the committee to perform a clinical examination, if necessary.

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

Date:_____

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