Case #:________

PATIENT REQUEST FOR MEDIATION

Confidential

Upon receipt of this completed form, a mediator will be assigned and will contact you within 30 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 a refund should not be made in writing or on this form. This option should be addressed during the mediation process.

Patient Information:

Name:____
First Middle Last

Address:____

City:______________________________ State:__________ Zip:__________________

Please provide a phone number and the best time of day for the mediator to contact you.

Area/Phone:______________________________ Time:______________________________

Dentist Information:

Name:______________________________ Area/Phone:______________________________
First Middle Last

Address:____

City:______________________________ State:__________ Zip:__________________

Date of last appointment:______________________________

Describe the problem(s) specific to the dental treatment received. Attach additional sheets if needed. Please print or type:

____

____

____

____

____

____

____

____

Thank you for addressing your concerns to the South Carolina Dental Association. Please return your complaint to: **SCDA, Attn: Mediation, 120 Stonemark Lane, Columbia SC 29210.** If you have any questions in the meantime, please do not hesitate to call 800.327.2598 or 803.750.2277.

In order that a complete review is performed, I authorize the release to this 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. I also understand that a copy of this mediation request form and all accompanying forms will be offered as explanation to the dentist who is a party to these proceedings.

______________________________________ ______________________
Signature Date