PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form, a mediator will be assigned and will contact you to discuss your request and help resolve this 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.**

Patient Information:

Date___/__/__ County_____

Name_____Phone #_____

Address_____

City_____State_____Zip Code_____

Name of Dentist:

Name_____Phone #_____

Address_____

City_____State_____Zip Code_____

County_____ Date of Last Appointment _____/____/____

Please Describe the Problem(s) Specific To The Dental Treatment Received:

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Thank you for addressing your concerns to the North Carolina Dental Society. Please provide below a phone number and the best time of day when the mediator will be able to contact you. If you have any questions in the meantime, please do not hesitate to contact the North Carolina Dental Society, 1-800-662-8754. (*Mail to: 1600 Evans Road, Cary, NC 27513)*

Day Phone: _____ Time: _____

Night Phone: _____ Time: _____

In order that a complete review can be 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 understand that a copy of this form may be shared with the dentist in question.

_____
Signature

Please return this form to:
Patricia Cardin
NC Dental Society
1600 Evans Road
Cary, NC 27519