NORTHERN VIRGINIA DENTAL SOCIETY
4330 EVERGREEN LANE, SUITE N
ANNANDALE, VA 22003

PATIENT REQUEST FOR MEDIATION

Please complete this form and return to the Northern Virginia Dental Society at the above address. While a refund of the charges that you have paid is one of the options that may be recommended by the mediator, requests for refunds to you or to another dentist should not be made in writing on this form**.** Upon receipt of this completed form, a mediator will be assigned and will contact you within three weeks to help resolve the issue.

PATIENT INFORMATION:

Date____________________________

NAME____ PHONE____

ADDRESS____

CITY___________________________________STATE____________________ZIPCODE____________________

NAME OF DENTIST:

NAME____ PHONE____

ADDRESS____

CITY___________________________________STATE____________________ZIPCODE____________________

DATE OF LAST APPOINTMENT _______________________________________

PLEASE DESCRIBE THE PROBLEM SPECIFIC TO THE DENTAL TREATMENT RECEIVED:

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

Day phone____ Time_______________________

Evening phone____ Time_______________________

In order that a complete review be performed, I authorize the release to this committee of any dental records or information by anyone who has examined me previously.

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(Signature)

Thank you for cooperating with the Northern Virginia Dental Society. Please contact us at 703 642-5297 if you have further questions.