

**TENNESSEE DENTAL ASSOCIATION  
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 the issue. A refund of the charges you have paid to the dentist involved **is one** of the options that may be recommended by the mediator. **However, a request for a refund should not be made in writing nor should the complaint be made against more than one dentist on this form. If either are noted, the form will be returned to you.**

**Patient Information:**

Date \_\_\_\_\_ Case # \_\_\_\_\_ (TDA office use only)  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please provide below a phone number and the best time of day when the mediator will be able to contact you.

Day Phone (\_\_\_\_\_) \_\_\_\_\_ Time \_\_\_\_\_

Night Phone (\_\_\_\_\_) \_\_\_\_\_ Time \_\_\_\_\_

**Dentist Information: MUST PROVIDE FIRST AND LAST NAME TO BE PROCESSED**

Name \_\_\_\_\_ Phone number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of last appointment \_\_\_\_\_

**Patient Release:**

I hereby give the TDA Peer Review Committee mediator my permission to disclose my name and dental complaint information to the dentist about whom I am filing the complaint.

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.

\_\_\_\_\_  
Signature

**State your complaint on the reverse side of this form or attachment.**

*Please return completed form to:*

***TDA PEER REVIEW • 660 Bakers Bridge Ave., Suite 300 • Franklin, TN 37067***

