Patient Request for Mediation Form

Confidential

Upon receipt of this completed form, a mediator will be assigned and will contact you to discuss your request and to 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 on this form. Submit form to Angie Deacon at angiebdeacon71@gmail.com or TDA, P. O. Box 986, Virginia Beach, VA 23451

Patient Information:

Date _____ **Case #** _____

Name _____ **Phone #** _( )_____

Address _____

City _____ **State** _____ **Zip** _____

Name of Dentist:

Name _____ **Phone #** _( )_____

Address _____

City _____ **State** _____ **Zip** _____

Date of Last Appointment _____

Please describe the problem specific to the dental treatment received:
Please print or type

Thank you for addressing your concerns to the Dental Association.

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 Dental Association, (757) 351-6767.

Day Phone (___) _____ Time: _____

Night 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, I further give my permission for the committee to perform a clinical examination if necessary.

_____

Signature