Arizona Dental Association
Central, Northern and Southern Societies
Mediation Program

Patient Agreement Form

The Arizona Dental Association (AzDA) has been requested to review the dental services provided to you in __________________________________by:
City

Dr.______________________________________ __________________________
Dentist named in complaint date of treatment

According to the AzDA Mediation Manual, both you and the dentist must consent to the review by AzDA and the applicable Component Society. As a requirement of membership in AzDA, the above-named dentist has agreed to be bound by the decision of the Mediation Committee. Therefore, his or her signature is not necessary.

I __________________________________ definitely understand and agree to the following:
Patient or parent/legal guardian/custodian

1. The AzDA, and any of their members and employees, are released from any and all liability resulting from or arising in any manner from the review of dental services you received. Therefore, you agree that none of these organizations or individuals will be sued (by you) with respect to this review.
2. By virtue of the Arizona Statute 36-2403, neither the records nor any proceedings relating to this matter of the Mediation Committee, or the AzDA's Council on Ethics and Mediation Services can be provided or used to reveal information in any manner.
3. No recovery for pain and/or suffering or time away from work exists in the Mediation System, and the decision by the Mediation Committee cannot compensate for any damages of this nature suffered.
4. The case will be dropped by AzDA should a complaint be filed with BODEX (Arizona State Board of Dental Examiners) or formal legal action be taken. I also agree to notify AzDA should I file a complaint with BODEX or begin formal litigation against the above-named dentist.
5. I declare that I am now making any and all complaints or claims against the dentist that I believe exist of any nature whatsoever.

Your signature below shows your acceptance of and agreement to all items listed above. Any alterations made in this form will prevent its acceptance and your case into the Mediation System.

Approved and accepted this ___________ day of _____________________, 20 _______

Signed ____
Patient or patient's parent/legal guardian/custodian

Complete and Return along with Record Release and Request for Review Forms to:

3193 Drinkwater Blvd
Scottsdale, AZ 85251

Telephone: 480-344-5777
Fax: 480-344-1442
Email: jan@azda.org

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Request for Review

This form will give the review committee some of the necessary important background information. Without it the review cannot be conducted. Please clearly type or print (black ink) the information. **If this form is not readable by the Committee, you will be asked to redo the form and resubmit it to the Committee.** Also, the more clearly you describe the situation or problem, the more effective the review committee can be.

PATIENT INFORMATION

Patient's Name____

Address____

City ____________________ State __________ Zip________

Daytime phone ( ) ______________ Evening phone ( ) ____________

Parent/Guardian (if patient is under 18)__________________________

Email address (if applicable)________________________________

Address____

City ____________________ State __________ Zip________

DENTIST INFORMATION

Dentist's Name ____

Address____

City ____________________ State __________ Zip________

Office phone ( ) ______________ Specialty (if any)______________

INSURANCE INFORMATION (if applicable)

Name of Insurance Company________________________________

Address____

City ____________________ State __________ Zip________

Name of Person Insured__________________________________

Social Security Number __________________ Group I.D. Number__________

Employer of Person Insured________________________________

Form continued on reverse

PEER REVIEW CASE INFORMATION

Date Treatment Began________________________ Date Treatment Ended________________________

Date patient was last seen by this dentist____

Date problem was first apparent______________________________

Have you tried to settle this matter directly with the dentist? ❐ Yes ❐ No

On what date(s)? ______________________________________

Did the dentist respond? ❐ Yes ❐ No If yes, what action was taken? ______________

____

Have you been treated for this problem by another dentist(s)? ❐ Yes ❐ NO
If yes, please give name(s), address(es) and phone number(s) on a separate sheet of paper.

Have you asked for help from any person, organization or agency? ❐ Yes ❐ No
If yes, please give name(s), address(es) and phone number(s) on a separate sheet of paper.

Are you aware of any litigation concerning the complaint (including small claims court)?
❐Yes ❐ No
Please explain the type of action being taken on a separate sheet of paper.

Do you currently have dental insurance? ❐ Yes ❐ No

Has your insurance company been notified of this matter? ❐ Yes ❐ No ❐ Not Applicable

Did your insurance pay for any portion of this treatment? ❐ Yes ❐ No ❐ Not Applicable
If yes, please provide amount. $ ______.____

How did you become aware of our Mediation System? ________________________________

____

On a separate sheet of paper, please describe your complaint in detail. Please be as specific as possible; the more information given to the Mediation Committee the better they are able to reach a fair decision. Include copies of any the dentist's bills, correspondence, and other related information.

I, ________________________ understand that the Mediation Services handles only matters relating to appropriateness and/or quality of care. The Mediation Committee cannot handle problems about prices/fees charged.

Patient's Signature ____ Date ______________

Parent/Guardian Signature ___________________________________ Date ______________

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Record Release Form

This form is necessary because it allows the review committee to examine your dental records or those of the person in your care. Without this information, the committee cannot begin its review. Please complete this form in its entirety, including your signature, and return to the address noted below.

The parties signing below request and give permission to:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Please list above the treating dentist (named in the complaint), other you have seen regarding this matter, and your insurance carrier, if applicable.

Please provide to the Arizona Dental Association (AzDA) any and all information about.

____

Records include: items with respect to dental care and treatment, medical care and treatment, illness or injury, dental history, medical history, and consultations; prescriptions; x-rays, plates; and copies of dental medical, and/or hospital records.

I also give permission to AzDA and the applicable Component Society to examine, as appropriate, the patient named above. **NOTE:** *A photocopy of this permission paper will be as effective and valid as the original.*

Signed ____
Patient

Signed ____
Parent, legal guardian or custodian

Date ____________________

Address of patient ____

____

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