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

City

Dr. ___________________________________________ date of treatment

Dentist named in complaint

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:

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
Arizona Dental Association
Central, Northern and Southern Societies
Mediation Program

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