Patient Request Form

Upon receipt of this completed form, a mediator will be assigned to discuss your request and 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.

Patient Information: (Please Print) Date: Case number:
Name:
Phone: (H) (W) (C)
Address:
City: State: Zip:
Dentist Information:
Name:
Phone:
Address:
City: Zip:
Date of Last Appointment:
Please describe the problem(s) specific to the dental treatment received:

Thank you for addressing your concerns to the Southern Maryland Dental Society. Please return this form to: 4920 Niagara Road, Suite 306, College Park, Maryland 20740
Please provide a phone number below, and the best time of the day when the mediator will be able to contact you. If you have any questions in the meantime, please do no hesitate to contact the Southern Maryland Dental Society at 301-345-4196.
Please include your Day Time Phone No:_____
and your Evening Phone No:_____
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