CONFIDENTIAL

PATIENT REQUEST FOR PEER REVIEW

KANSAS DENTAL ASSOCIATION

PATIENT INFORMATION

Title: ❑ Miss ❑ Ms. ❑ Mrs. ❑ Mr. ❑ Dr.* *Please list profession ___________________

Name: ____

Street Address: ____

City: __________________________ State: ______________ ZIP: ____________

Phone: (_______) _______ - _______ Email: ___________________________________

May we contact you via email? ❑ Yes ❑ No

DENTIST INFORMATION

Name: ____

Street Address: ____

City: _________________________ State: ______________ *(Dentist must be from Kansas)* ZIP: ____________

Phone: (_______) _______ - _______

COMPLAINT INFORMATION

Have you contacted the dentist office about your concerns? ❑ Yes ❑ No

Do you have a case pending with the Kansas Dental Board concerning this case? ❑ Yes ❑ No

When was your last appointment with the dentist? ___________________________________

Please describe the problem(s) specific to the dental treatment received. While a refund of any charges you may 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 or on this form:

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I certify that I am at least 18 years old and am the patient or the parent/legal guardian of the patient. In order that a complete review be performed, I understand that I must authorize the release of any dental records or information by anyone who has examined the patient previously, to the Kansas Dental Association Council on Peer Review.

Signature ___________________________________ Date ____________________________________

Thank you for addressing your concerns to the Kansas Dental Association Council on Peer Review.

CF1 - Rev. 10/29/2014