



## Oregon Negligence/Malpractice Claim Report Form

# Oregon Board of Dentistry

1600 SW 4th Avenue, Suite 770 • Portland, Oregon 97201

(971) 673-3200 • [www.oregon.gov/Dentistry](http://www.oregon.gov/Dentistry)

Per ORS 742.400 (4), "...any insurer required to report to a board under this section shall also be required to advise the appropriate licensing board of any settlements, awards or judgments against a physician, optometrist, *dentist or dental hygienist* or naturopath within 30 days after the date of the settlement, award or judgment..." **The form below should be completed for every claim received by the reporting entity.** Please send the printed, completed form to the Oregon Board of Dentistry at the address above.

Insurer Name:	NAIC #:	Claim File ID:
---------------	---------	----------------

Contact Person:	Phone #:
-----------------	----------

Mailing address:	City:	State:	Zip:
------------------	-------	--------	------

### Covered Practitioner (DMD, DDS, RDH only):

License #:	Name:	Date of Birth:
------------	-------	----------------

Address:	Phone: ( )
----------	------------

City:	State:	Zip:
-------	--------	------

### Injury/Incident Data:

Injured person's name:	Age:	<input type="checkbox"/> M <input type="checkbox"/> F
------------------------	------	---

Date of injury:	Date reported to insurer:	If re-opened, date re-opened:
-----------------	---------------------------	-------------------------------

Is Claim Court-Filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date Filed in Court:
--	------------------------------

If Filed in Court, Name and Location of Court:

Plaintiff attorney's name:	Address:
----------------------------	----------

City:	State:	Zip:
-------	--------	------

**Allegations and reasons for claim. State patient's actual, original, abnormal condition and any material diagnosis, procedure, planning error, medical injury or other allegation: (Attach a copy of the complaint to this sheet)**


### Closure Data:

Closure date:	Claim disposition (code):	Settlement (code):	Court (code):
---------------	---------------------------	--------------------	---------------

<input type="checkbox"/> Deductible <input type="checkbox"/> Exceeds Deductible	Economic	Non-economic	Punitive	Unspecific
---	----------	--------------	----------	------------

Indemnity insurer paid on behalf of defendant:	\$	\$	\$	\$
--	----	----	----	----

Other indemnity paid by/on behalf of defendant:	\$	\$	\$	\$
---	----	----	----	----

Indemnity paid by all parties (for all defendants):	\$			
---	----	--	--	--

Loss adjustment expense paid to defense counsel:	\$	All other allocated loss adjustment expenses paid:	\$
--	----	--	----