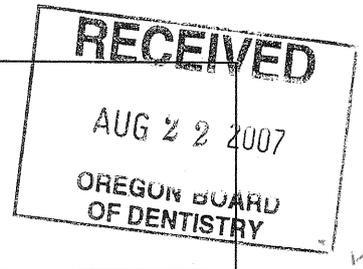




Department of Consumer & Business Services  
 Insurance Division Rates & Forms  
 350 Winter St. NE, Room 440-5  
 Salem, OR 97310-0765  
 Phone (503) 947-7983



***Oregon Medical/Dental Negligence Claim Report Form***

NAIC No: \_\_\_\_\_

A separate form for each claimant-Insured pair is to be completed for each claim within 30 days of notice to insurer and again when closed, including claims closed without payments.

Insurer name: FORTRESS Insurance Co. Claim file ID: \_\_\_\_\_

**Physician/Dentist**

License no: D6536 Name: Regan, Michael Age: \_\_\_\_\_

Address: 6969 SE Lake Road Milwaukee OR 97267  
City State ZIP

Profession/business (code): \_\_\_\_\_ Specialty (code): \_\_\_\_\_ Board certified (code): \_\_\_\_\_ Other spec.(code): 80211

Practice type (code): \_\_\_\_\_ Foreign medical graduate?  Yes  No Country (If Yes): \_\_\_\_\_

**Injury Data**

Injured person's name: Corno Shawn Age: \_\_\_\_\_

**Allegations and reasons for claim. State patient's actual, original, abnormal condition and any material diagnosis, procedure or planning error, medical injury or other allegation:**

IF MORE INFO DOESN'T FIT GO TO NEXT PAGE: Following extraction of #16 and #32, the patient alleges that right lingual nerve was injured, resulting in paresthesia, pain, and need for surgery. Good informed consent and timely referrals.