

Dental Malpractice Claim Questionnaire

Please Email a copy of this form to dentalmalpractice@murphybattista.com with the Subject line: **Dental Malpractice Claim** and our office will contact you to confirm receipt and next steps.

Full Name: _____

Date of Birth: _____

Preferred Phone: _____ Preferred Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

What dental procedure or treatment is the main cause of your concern?

What injury or symptoms are the main cause of your concern?

Approximately on what date or dates did you receive treatment or procedure that you are concerned about?

How did you hear about Murphy Battista LLP?

Personal information that you provide to us for the purpose of determining your possible involvement in a dental malpractice claim will be treated as private. [Read our privacy policy for more information.](#)

I have read and agree to the disclaimer