

# Colorado Dental Association's Peer Review

## Request for Review of Dental Services

CDA File # \_\_\_\_\_ (CDA Use)

This form will give the Colorado Dental Association's Peer Review committees necessary background information. Without this form properly completed a review cannot be conducted. The more clearly and concisely you describe the situation or problem, the more effective the review committee can be. **(PLEASE TYPE OR PRINT CLEARLY.)**

Have you filed a lawsuit or a complaint with the State Board of Dental Examiners regarding this matter? \_\_\_\_\_  
**If so this does NOT fall under the scope of Peer Review.**

Name of person requesting review: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_  
City State Zip

Telephone: Home (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Parent or Guardian \_\_\_\_\_  
(If patient is under 18 years old) (Relationship to Patient)

Name of Dentist: \_\_\_\_\_ Telephone: Office: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Date treatment started: \_\_\_\_\_ Date treatment completed: \_\_\_\_\_

Date last seen by dentist: \_\_\_\_\_

Date problem first recognized: \_\_\_\_\_

Have you discussed concern with dentist? \_\_\_ Yes \_\_\_ No If yes, what dates: \_\_\_\_\_

Did dentist respond? \_\_\_ Yes \_\_\_ No

If yes, what action was taken?: \_\_\_\_\_

Total fees charged: \_\_\_\_\_ Total amount paid by patient: \_\_\_\_\_

Total amount paid by primary insurance company: \$ \_\_\_\_\_ Paid to DDS: \_\_\_\_\_ to Patient: \_\_\_\_\_

Have you been examined or treated by another dentist(s) for this problem? \_\_\_ Yes \_\_\_ No

If yes, please list name and telephone numbers of the other dentist(s):

Dentist(s) Name: \_\_\_\_\_ Office Telephone (\_\_\_\_) \_\_\_\_\_

