Quality Resource Guide

Management of Malpractice Risk in Dental Practice

Author Acknowledgements

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Educational Objectives

Following this unit of instruction, the learner should be able to:

1. Recognize and understand the most common legal claims brought against dentists.
2. Recognize when it may be advisable to refer dental care to a specialist.
3. Recognize and understand the importance of preventing common nerve injuries during surgical dental procedures.
4. Recognize and understand the importance of doing a "timeout" prior to performing a dental procedure.
5. Recognize and understand that most dental malpractice claims are preventable.
6. Recognize and understand the importance of patient communication and the concept of a team approach to patient care to reduce risk of malpractice claims.

MetLife designates this activity for **1.0 continuing education credits** for the review of this Quality Resource Guide and successful completion of the post test.

The following commentary highlights fundamental and commonly accepted practices on the subject matter. The information is intended as a general overview and is for educational purposes only. This information does not constitute legal advice, which can only be provided by an attorney.

Originally published December 2013. Updated and revised December 2016 and March 2024. Expiration date: March 2027.

The content of this Guide is subject to change as new scientific information becomes available.

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Introduction

Malpractice is medical/dental negligence. In healthcare situations, malpractice may include treatment that fails to meet the standard of care, lack of treatment when indicated, failure to refer in a timely manner, improper prescribing of medication, or departure from accepted care or safety on the part of a health care provider that causes harm to a patient. Dental negligence is a lack of due care and is generally preventable.

The good news for dentists is that most medical negligence trial lawyers typically do not pursue dental cases. While the lawyer's preparation and expense for such cases are similar to physician cases, the potential value of a dental case usually does not justify the time or expenditures. Dental cases are generally only pursued if the case is solid on liability and straightforward in causation and damages. Despite its infrequent occurrence, it is in the best interest of the dental practitioner, the dental patient, and the dental profession to lower the incidence of negligent dental care.

Certain dental cases have jury appeal, either because of the nature of the injury, or because the injury will cause the plaintiff to incur substantial out-of- pocket expenses. Obviously, death and catastrophic injury, sustained as a result of dental treatment or due to negligent administration of anesthesia or negligent resuscitation, are serious cases that usually result in legal recourse. There are cases having non-catastrophic outcomes that are successfully tried against dentists. Most dental/medical malpractice cases are preventable, if the practitioner and the office staff use proper preventive steps. This Quality Resource Guide will discuss the most common claims being brought against dentists by plaintiffs. The dentist will learn how to recognize the different categories of claims and how to avoid them. The dentist will gain a greater appreciation for adopting a "team" approach for patient management, and understand the importance of patient communication and well-trained office support staff.

Most dental malpractice cases may be broken down into the following categories:

- Implant Therapy
- Third Molar Removal
- Endodontic Therapy
- Prosthetic Therapy
- Over-Adjustment of the Occlusion
- Failure to Diagnose and Treat Periodontal Diseases
- Failure to Diagnose and Treat Oral Lesions
- Inappropriate Pharmacologic Pain Management
- Lack of Informed Consent
- Medical Battery

General dentists can be held to the standard of the specialist for any treatment performed within the scope of the specialist. It is imperative every dentist assess their level of expertise prior to undertaking any complicated treatment.

Implant Therapy

General dentists and various dental specialists (*e.g.,* oral and maxillofacial surgeons, prosthodontists, periodontists) place implants to support prosthetic replacement of teeth. The most common injuries during implant placement are to the inferior alveolar nerve, usually caused by placing an implant that is too long into an area with insufficient bone. Typically, this situation is caused by the failure of the practitioner to properly determine the amount of available bone and the location of anatomical structures within the surgical site. These injuries may best be avoided by the use of a computed tomography (CT) scan, typically a "cone-beam CT" in dental practice, to determine the height and width of the available bone, and the location of the inferior alveolar nerve. The CT scan gives an accurate 3-dimensional view of the mandible and the position of the inferior alveolar nerve. Practitioners are negligent if they fail to accurately account for the position of the inferior alveolar nerve and the amount of available bone and/or choose an incorrectly sized implant for the site.

Given the serious nature of injury to the inferior alveolar nerve, the general lack of any serious contraindications to obtaining a CT scan of the mandible, and the relative low cost of the scan, it is prudent to obtain a CT scan prior to placing an implant into the posterior mandible. Despite this favorable risk/benefit analysis for taking and using CT scans for implant placement in the posterior mandible region, there are dental "experts" for the defense who have testified that placing an implant in the posterior mandible without a pre-surgical CT is not necessarily below the standard of care.[1]

In **the** author's experience, dentists who obtain preoperative CT scans to aid in selection of proper sized implants typically do not become defendants in these cases. Dentists who become defendants in implant cases are usually practitioners who have relied on panoramic imaging and some educated "guesswork". Unfortunately, the dentist "guessed" wrong, placed implants that were too long for the available space, and caused injury to the inferior alveolar nerve. The second area of implant negligence litigated by lawyers involves poor implant treatment planning. These cases typically involve implants placed in positions or orientations that made them very difficult, or impossible, to restore. This is usually caused by: failure of communication between the implant surgeon and the practitioner who is going to restore the implant; failure to create a pre-therapy diagnostic wax-up to determine if there is enough space for the restorations; and/or failure to use a surgical guide during implant placement. The outcome in these situations can be poor cosmetics and/or function. Damages in these cases are often related to the removal of the malposed implants with resultant loss of bone. Implant replacement and restoration in these cases is often extremely difficult, very expensive, and come with a poor prognosis. Cooperation and pre-planning by the implant surgeon and restorative dentist is absolutely necessary to avoid these problems.

Third Molar Removal

The most common injury in mandibular third molar removal is to the inferior alveolar nerve, the lingual nerve, or both.[2] The risk of possible permanent nerve injury must be part of any informed consent discussion prior to removal of a mandibular third molar. Risk of injury to the inferior alveolar nerve increases for the patient over thirty (30) years of age, as the bone is not as pliable making it more susceptible to fracture, and there is an increased risk that the tooth may be ankylosed. Performing a thorough presurgical evaluation often helps identify procedural risks beyond the practitioner's expertise.

A relatively inexperienced general dentist may also encounter problems with the actual removal of the tooth: pushing teeth into the sinus; fracturing roots; and injuring nerves. When surgical complications arise that are beyond the practitioner's level of expertise, the patient should immediately be referred to an oral and maxillofacial surgeon to avoid more serious postoperative complications.

Practitioners may be held negligent if the lingual nerve is severed or transected. An "injury" to the lingual nerve is usually not enough to establish liability, as there are a host of factors that can cause lingual nerve injury. Typically, condemning evidence reveals that the surgeon's instruments were positioned too far lingual, transecting the nerve, or there is a dental bur groove in the lingual plate. Practitioners must make every effort to protect against severing the lingual nerve, as it is a devastating permanent injury for the patient.

Any post-surgical indication suggesting damage to the inferior alveolar nerve or lingual nerve (*e.g.,* anesthesia, paresthesia, dysesthesia, hyperalgesia, allodynia, hypoesthesia and hyperesthesia) should be immediately referred for consultation to an oral and maxillofacial surgeon for assessment and management as needed. While the vast majority (90%) of these injuries are temporary and get better within eight weeks, persistence after six months are considered permanent.[3,4] If there is not significant sensory recovery in a traumatized nerve by three months, corrective microsurgery may be indicated.[4] Patients waiting more than nine months for nerve repair have a significantly decreased chance of attaining a satisfactory outcome.[5] A dentist may be held negligent if a nerve is damaged and he/she fails to refer the patient for repair within an appropriate timeframe.

Endodontic Therapy

In the author's experience, general dentists at legal risk have either over-instrumented a canal or failed to locate all of the canals. Over-instrumentation of a mandibular root canal, causing filling materials to extrude from the apex and enter the mandibular canal, may cause permanent nerve injury. Over-instrumentation of a canal in a maxillary tooth may result in extrusion of filling materials into the maxillary sinus, potentially leading to infection and chronic sinusitis.

General dentists without extensive clinical experience in providing molar root canal therapy should carefully consider referring treatment of molars, especially those with complex pulpal anatomy, to an endodontist. Inappropriate instrumentation or loss of control of the endodontic file can result in significant complications (*e.g.*, swallowing, aspiration).[6,7] Not locating a canal or failing to properly clean a canal can lead to significant infection, potentially requiring treatment of submandibular swelling and airway compromise. Poor documentation of the endodontic record and failure to use a rubber dam during therapy can also put a dentist performing root canal therapy at legal risk. The American Association of Endodontists Position Statement states "Tooth isolation using the dental dam is the standard of care; it is integral and essential for any nonsurgical endodontic treatment."[8]

Prosthodontic Therapy

Improper placement of crowns and bridges is another category of dental negligence. The placement of permanent or temporary crowns and bridges with open margins, poor contours, hyperocclusion, and/or lack of occlusion or embrasure space, constitutes negligence. Crowns placed with open margins generate many legal suits. Most of these cases come with a ready-made expert witness for the patient, namely the subsequent dental care provider. Many patients do not find out about their improperly placed crowns or bridges until a subsequent dental professional brings it to their attention. Redoing an improperly placed dental prosthesis can be very costly and time consuming. Because of the expectation that dental care should have been done correctly in the first place, and the fact that the redo is going to be costly, these cases tend to have jury appeal as consumer protection cases. Often the evidence is very easy to present to the jury and settlements are easily achievable.

Over-Adjustment of the Occlusion

Dentists increase their risk for a potential malpractice claim when they perform irreversible occlusal adjustments in a haphazard and/or non-recorded fashion. Legal cases arising from occlusal adjustment typically involve practitioners who did not record the results of an examination and/or a diagnosis substantiating the reason for occlusal adjustment or did not create a record of the teeth that were treated.[9] The patient's occlusion was over-adjusted and vertical dimension was compromised. Rebuilding the correct bite in these situations is very difficult and many of these patients end up seeking treatment from a plethora of providers in their attempt to get relief, often at great expense. Settlements in this area may be substantially increased if the patient demonstrates TMJ symptoms and/or if the TMJ status was not well documented prior to the adjustments.

Failure to Diagnose and/or Treat Periodontal Disease

Cases involving failure to diagnose and/or treat periodontal diseases are relatively uncommon. Most involve general dentists who have been treating a patient for many years and typically, there is no documentation of periodic periodontal examinations or appropriate diagnostic images. A conclusion is quickly derived that supervised neglect occurred. The outcome may be loss of all teeth and the need for subsequent prosthetic replacement. Often these patients have a history

of multiple dental visits and were scrupulous about attending their appointments. It is usually a subsequent provider that breaks the bad news to the patient.

Documentation of the periodic and regular assessment of the patient's periodontal status and appropriate therapy, or referral to a periodontist, is mandatory. If the patient does not comply with recommendations, they must be informed of the consequences of their non-compliance, and this must be noted in the record. Many organizations provide guidance on the standard of practice for a hygiene maintenance and the dentist should familiarize themselves with these standards.[10]

Failure to Diagnose and/or Treat Oral Lesions

Failure to diagnose and treat, or refer, an oral lesion that later progresses to a point where it is not curable, is negligence. Cases involving oral lesions (typically on the lateral border of the tongue) are usually those that were not biopsied and progressed to advanced cancer.[11] It is very important that the practitioner periodically conduct a review of the medical/dental history and accomplish a thorough head & neck examination on every patient. If the practitioner notes a lesion, they should schedule the patient for a follow-up evaluation in 10-14 days, and document if the patient fails to keep the appointment. The dentist should not tell the patient to do self-examination and return only if it does not go away or worsens.

Given the severe consequences if cancer is left untreated, it is imperative that the dentist follow any equivocal lesion aggressively and perform, or refer for, a biopsy of a lesion that has not gone away within two weeks. The size, location and description of the lesion must be documented as well as all follow up appointments.

The diagnostic reason for taking a radiograph should be documented as well as the findings from interpreting the radiograph images. Radiographic images should be reviewed thoroughly. Equivocal radiolucent or radiopaque lesions should be biopsied or referred for evaluation and management as appropriate.

Inappropriate Pharmacologic Pain Management

A relatively new area of concern in dental liability is the inappropriate prescribing of opioid (narcotic) pain medications in the management of acute dental-related pain. The dental profession has been increasingly scrutinized for its prescribing patterns ever since a 2013 study of prescribing patterns in South Carolina showed that 44.9% of first-time filled opioid prescriptions were from dentists.[12] Another study revealed that 54% of opioid pills prescribed by dentists go unused, creating a risk for diversion with the retrospective data showing a high correlation between dental prescribing and opioid dependence.[13]

Contemporary research confirms that for acute dental-related pain management, nonopioid medications (NSAID +/- acetaminophen) represent first-line therapy and the use of opioids should be reserved for the infrequent clinical situations where the first-line therapy is insufficient to reduce pain or there is a contraindication for the use of NSAIDs.[14]

Dentists must be in compliance with their state's regulatory requirements pertaining to opioid prescribing and documentation as to why the opioid was indicated. While improper prescribing could result in criminal prosecution, the patient or patient's family may also seek damages for allegations of not screening the patient for opioid dependency or for contributing to its development.

Informed Consent*

Malpractice cases linked to a "stand-alone" lack of informed consent are relatively uncommon. Typically, lack of informed consent is "bundled" with negligent diagnosis and treatment claims. It can be difficult to prove a "stand alone" lack of informed consent.

Informed consent requirements vary from state to state. Some states, such as Massachusetts, adhere to the requirement that informed consent mandates disclosure of "material" risks, including risks associated with non-treatment.[12] The premise is that a practitioner must give the patient enough information to make an "informed" decision. What is a "material risk"? "Materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment."[13] That "materiality" decision is left to a judge or jury to determine. There is no "bright line" percentage, to determine what is "material". For example, a statistically low risk may still be "material", if it can cause great harm. It must be something that a reasonable patient would want to know, before making a decision to undertake treatment. For example, permanent nerve injury following surgical removal of a third molar, while occurring relatively infrequently, is something a reasonable patient would want to know. The plaintiff must also prove that the "risk" materialized. This information typically requires expert testimony. Any special risks that the patient is exposed to, due to his or her medical status (diabetes, cardiac heart disease) must also be disclosed, preferably in the consent form.

* A more specific discussion of informed consent in the dental office may be found in the MetLife Quality Resource Guide, *Informed Consent in the Dental Setting.*

Medical Battery

Medical battery occurs when a patient is treated without informed consent. Most commonly, battery charges are alleged where there is a dispute over whether the patient agreed to treatment or refused treatment. Although not commonly brought forward in dental situations, a medical (civil) battery charge can be devastating to the practitioner because they are liable for all damages that flow from it, including emotional distress. In addition, the plaintiff does not need an expert witness to testify as to the standard of care.

Dental battery cases typically involve extracting the wrong tooth. A battery case could also arise from placing "veneers" (necessitating removal of enamel from the patient's front teeth) if the patient had only consented to a cosmetic procedure that required no removal of tooth structure. It is important to clearly document conversations regarding the nature and scope of the treatment to be rendered.

Conclusion

Most dental malpractice claims are preventable. Claims most often occur when dental practitioners attempt to deliver treatment beyond their level of expertise or perform outdated procedures. Dental professionals are obligated to stay current regarding contemporary diagnostic and treatment modalities. Dentists and their office staff also need to communicate effectively with each other and their patients.

There is no defense for performing the wrong procedure or treating the wrong tooth. Practicing a single "time out", prior to performing any procedure, to reassess the diagnosis and procedure to be completed along with the tooth and/or teeth to be treated, and confirmation with the patient, the record, the images, and trained support staff such as assistants and dental associates, should prevent errors underlying a claim for medical battery. Maintaining accurate and detailed records,** further helps reduce the risk of errors in diagnosis and treatment. Such records will also provide the dentist with a better defense in cases of alleged malpractice.

** A more specific discussion of dental record keeping may be found in the MetLife Quality Resource Guide, *Dental Record Keeping*.

Should a dentist experience a clinical situation where the outcomes of care for a patient are compromised, their best approach is to reveal the outcomes to the patient, discuss the options, including referral, that are available to correct and answer the patient's questions.

By definition, dental negligence is lack of due care. It is thus preventable.

Acknowledgement

The first two editions of this Guide were authored by Frank J. Riccio, DMD JD FCLM. Dr. Aksu reviewed and updated the material for the third Edition.

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POST-TEST

Internet Users: This page is intended to assist you in fast and accurate testing when completing the "Online Exam." We suggest reviewing the questions and then circling your answers on this page prior to completing the online exam.

(1.0 CE Credit Contact Hour) Please circle the correct answer. 70% equals passing grade.

1. **What imaging modality gives the most information regarding available bone for the placement of a mandibular implant?**
   a. Bitewing
   b. Panorex
   c. Periapical
   d. CT scan

2. **In cases involving the placement of crowns and bridges, which deviation from the standard of care results in the most malpractice claims?**
   a. Open margins
   b. Aesthetic failure
   c. Comfort problems
   d. Function problems

3. **In patients who present with an oral lesion, what is the recommended time to schedule the patient to return for follow- up?**
   a. 1 year
   b. 6 months
   c. 2-5 days
   d. 10-14 days

4. **How do patients typically learn that they have had longstanding, but undiagnosed, periodontal disease?**
   a. Subsequent treating dentist
   b. A spouse
   c. The in-office hygienist
   d. The present dentist and potential defendant

5. **Which of the following is (are) (a) typical deviation(s) from the standard of care that general dentists make in managing molar endodontic therapy:**
   a. Over-instrumentation of a canal
   b. Failure to refer to an endodontist
   c. Failure to find all of the canals
   d. All of the above

6. **Relative to informed consent, in states such as Massachusetts, a plaintiff must prove:**
   a. The risk was a material
   b. The dentist did not disclose a material risk
   c. The risk actually happened
   d. All of the above

7. **Medical battery (civil):**
   a. Involves only physicians
   b. Is when a practitioner hits the patient
   c. Involves performing a procedure that was not consented to
   d. Is never preventable

8. **What is not medical battery?**
   a. Taking out the wrong tooth
   b. Preparing teeth for veneers or crowns, on a patient scheduled for non-invasive procedures
   c. Extending an amalgam prep from an occlusal prep to an interproximal prep because of undermining caries activity*
   d. None of the above

9. **How is medical battery preventable?**
   a. Performing a "timeout" with the patient prior to performing a procedure
   b. Reviewing the patient's records and images prior to the treatment
   c. Communicating with the patient prior to the procedure
   d. All of the above

10. **Most medical malpractice lawyers do not pursue malpractice claims against dentists, because of the limited damages.**
    a. True
    b. False

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