Per E-Mail senden | Formular drucken

Guarantee Form

Customer information

Name

Address

Customer ID

Telephone

Country

Product information (please list all Biodenta products concerned)

Reference number	Lot number	Fitting Date (DD/MM/YY)	Removal Date (DD/MM/YY)	Location of removed implants

General patient information

Patient ID

Age

☐ Female ☐ Male

Medical history:

☐ Xerostomia
☐ Illness requiring steroids
☐ Unchecked endocrine illness
☐ Compromised immunoresistance
☐ Diabetes melitus
☐ Alcohol / drug abuse
☐ Radiation Tx-head / neck area
☐ Lymphatic disorder
☐ Psychological disorder
☐ Chemotherapy at the time of implant fitting
☐ Blood coagulation disorder

Does the patient smoke more than one pack of cigarettes per day? ☐ Yes ☐ No

Allergies:

Other relevant diseases:

☐ No significant findings

Implant failure – Surgical information

☐ Manual fitting ☐ Handpiece fitting

If the implant was fitted and removed on the same day, was another implant inserted successfully in the same place?
☐ Yes ☐ No

Were any of the following items present at the time of surgery?

☐ Periodontal disease
☐ Disease of mucous membrane
☐ Local infection / subacute chronic osteitis
☐ Complication in site preparation
☐ Problems with bone quality ☐ Type I ☐ Type II ☐ Type III ☐ Type IV

If you experienced difficulty with inserting device / pre-mounted transfer where did this occur?

☐ Implant insertion into bone
☐ Removal of the implant from vial
☐ Removal of device from implant
☐ Other:

Was the site tapped?	☐ Yes	☐ No	☐ Not applicable
Was primary stability achieved?	☐ Yes	☐ No	
Did implant achieve osseointegration?	☐ Yes	☐ No	
Was the implant surface completely covered with bone?	☐ Yes	☐ No	

Was an augmentation performed at the time of surgery?

☐ No ☐ Ridge ☐ Sinus Material used:

Was a GTR-membrane used?

☐ No ☐ Yes ☐ Re-absorbable ☐ Non-re-absorbable

Material used:

Further information

Hygiene involving the implant ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Were any of the following points involved?

☐ Nerves encroachment ☐ Peri-implantitis ☐ Adjacent to endodontic tooth
☐ Infection ☐ Biomechanical overload ☐ Inadequate bone quality / quantity
☐ Immediate implant fitting ☐ Trauma / accident ☐ Previous bone augmentation
☐ Implant fracture ☐ Overheating of the bone ☐ Tongue
☐ Sinus perforation ☐ Bruxism ☐ Other: _____

At the time of implant failure, was the following diagnosed:

☐ Pain ☐ Bleeding ☐ Swelling ☐ Numbness
☐ Mobility ☐ Fistula ☐ Asymptomatic ☐ Other: _____

Was the prosthesis fitted? ☐ No ☐ Yes If yes, please fill out the section "information on prosthodontics".

Please explain why you think the implant failed or had to be removed:

Prosthesis information

Type of prosthesis ☐ Crown ☐ Bridge ☐ Partial prosthesis (upper) ☐ Partial prosthesis (lower)
☐ Full prosthesis (upper) ☐ Full prosthesis (lower) ☐ Telescope ☐ Other: _____

Date of abutment installation: _____

Date of abutment removal: _____

Was the torque control used? ☐ Yes ☐ No ☐ Unknown Torque applied: _____ Ncm

Date of temporary prosthesis installation: _____ Date of final prosthesis installation: _____

Were the control examinations carried out? ☐ Yes ☐ No

Comments:

Instruments **(fill out if instruments are returned)**

Approximate number of uses: (Cutting instruments only) ☐ initial use ☐ 2-5 ☐ 6-10 ☐ 10-15 ☐ More than 15

Type of cleaning method applied ☐ Manual ☐ Thermo disinfection ☐ Ultrasonic ☐ Other: _____

Type of sterilisation method applied ☐ Autoclave ☐ Chemiclave ☐ Dry heat

Short description of the incident:

Please return this form together with the autoclaved product and include X-ray photographs (as appropriate).

For return, please use a padded pouch – otherwise items may get damaged during shipment and the guarantee will become invalid.

Autoclave all products and label them as **"sterile"**.

Customer signature: Date: _____