DSI Dental Solutions | haAvoda 59 | Light Industrial Zone | Ashdod Israel

www.dsisrael.com

A-Not. no / Ref. QN # _____

Order No. (if used) _____

Complaint, implant failure (guarantee) and implant fracture

QUESTIONNAIRE

Please complete this form with as much detail as possible; ***missing information will delay processing***.
If appropriate, provide the explanted product(s) in sterile condition and any relevant radiographs (not returned unless requested). Attach sterilized product to this form or write the patient identifier and File Number (if known) on product package.
Products MUST be sterilized in pouches which show sterility with colour change or other indication. All written information MUST be (translated) in(to) English.

GUARANTEE CONDITIONS

• Products must be returned within ***90 days*** of the date of the event or device removal and ***Service duration*** must be within ***Guarantee Term limits***.
• Products must be shipped in ***protective packaging*** using a method that allows for shipment ***tracking***.

RESTORATIVE DOCTOR INFORMATION

(Written or stamped)

Sold to Account #	
Name	
Phone	
E-Mail	
Address	
City	
State/Prov	Postal Code

CUSTOMER INFORMATION

(Written or stamped)

Sold to Account #	
Name	
Phone	
E-Mail	
Address	
City	
State/Prov	Postal Code

PATIENT INFORMATION

(required for implants)

(for privacy DO NOT use patient's name)

Patient ID				
Date of Birth				
Gender	○	Female	○	Male
Smoker?	○	No	○	Yes

History

☐ Psychological disorder	☐ Blood coagulation disorder	☐ Illness requiring steroids
☐ Lymphatic disorder	☐ Untreated endocrine illness	☐ Coincident chemotherapy
☐ Drug or alcohol abuse	☐ Diabetes Mellitus	☐ Xerostomia
☐ Compromised immunity	☐ Radiation Tx (head/ neck area)	☐ No significant findings
Relevant allergies:	Relevant diseases:	

LIST OF RETURNED PRODUCTS

(Send ONLY STERILIZED products in pouches together with this completed form).

Article (REF) #	Lot/Serial #	Product Description	Qty	Tooth position*

PRODUCT INFORMATION

Date of implant placement:	Date of implant exposure:
Date of implant loading:	Date of implant removal:

PROBLEM DESCRIPTION

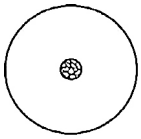
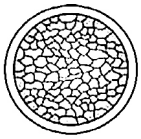
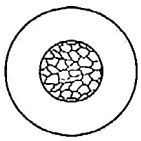
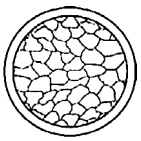
Problem type:	☐ Complaint	☐ Implant Failure (Guarantee)	☐ Implant Fracture
	☐ During receiving / unpacking	☐ During clinical procedure	☐ During laboratory procedure
	☐ Other		
Patient injury?	○ No	○ Yes	
	If YES, please explain:		
Describe problem:			

DEFINE THE PATIENT'S ORAL HYGIENE USING THE GINGIVAL HEALTH INDEX

☐ Normal	☐ Moderate inflammation, redness, edema and glazing, bleeding on probing
☐ Mild inflammation, slight change in colour, slight edema, no bleeding	☐ Severe inflammation, marked by redness, edema, ulceration, tendency towards spontaneous bleeding

Was granulated tissue identified around the implant?	○ No	○ Yes
Was the implant site infected?	○ No	○ Yes

DEFINE THE PATIENT'S BONE QUALITY IN THE AREA OF IMPLANT PLACEMENT

☐ Majority of the residual bone made of cortical bone 	☐ Thin layer of cortical bone surrounding medium-density spongy bone 
☐ Presence of thick cortical bone surrounding spongy bone 	☐ Thin layer of cortical bone surrounding low-density spongy bone 

DEFINE THE PATIENT'S BONE QUANTITY IN THE AREA OF IMPLANT PLACEMENT

☐ Most of the alveolar ridge is present

☐ Moderate residual ridge resorption has occurred

☐ Advanced residual ridge resorption has occurred and only basal bone remains

☐ Some resorption of the basal bone has started

☐ Extreme resorption of the basal bone has taken place

DOCTOR EVALUATION OF THE PROBLEM CAUSE

☐ Failure to osseointegrate – pre-loading (before exposure)	☐ Loss of osseointegration – post-surgical loading of implant
☐ Iatrogenic surgical trauma	☐ Diminished oral hygiene
☐ Bone quality insufficient	☐ Bone quantity insufficient
☐ Biomechanical overload or stress	☐ Broken component
☐ Pain	☐ Numbness
☐ Unknown	☐ Other cause:

REQUESTED REPLACEMENT COMPONENTS (max. value equal to returned products).

Article (REF) #	Lot/Serial #	Product Description	Qty

Signature confirming the stated conditions in this questionnaire:

Place and date: