



In case of a screw break, please only fill in sections marked with *

WARRANTY FORM Implantology

1. Customer information *

Name of physician: _____ Customer No.: _____
 Address: _____ Telephone: _____
 _____ Email: _____
 _____ Documented by: _____

2. Product information

| REF No.: | LOT No.: | Date inserted: | Date removed: | Regio: |
|----------|----------|----------------|---------------|--------|
| □□□□□□ | □□□□□□□□ | □□□□□□□□ | □□□□□□□□ | □□□□ |
| □□□□□□ | □□□□□□□□ | □□□□□□□□ | □□□□□□□□ | □□□□ |
| □□□□□□ | □□□□□□□□ | □□□□□□□□ | □□□□□□□□ | □□□□ |

3. Patient information

Patient ID: _____ Age: _____ F M
 Bone density D1 D2 D3 D4 Smoker? No Yes
 Medical history:
 Alcohol or drug abuse Blood coagulation disorder Chemotherapy during implantation
 Diabetes mellitus Compromised immune resistance Treatment with corticosteroids
 Lymphatic disorder Untreated endocrine disorders Psychic disorders
 Radiation therapy in head/neck region Xerostomy No relevant findings
 Immunological disorders Known allergies: _____
 Other relevant disorders: _____

4. Surgical information

If the implant was inserted and removed on the same day, was another implant inserted successfully in the same place? No Yes LOT: _____
 How was the implant inserted? Hand wheel Ratchet Angled handpiece Torque: _____ Ncm
 Did problems occur with the pre-mounted transfer part? No Yes _____
 Was one of the following points evident at the time of the intervention? Complication during preparation of the implant bed
 Periodontal disease Mucosal disease Local infection / subacute chronic osteitis
 What was the maximum speed employed during preparation? _____ min⁻¹
 Which drill was used last? _____ Ø _____ mm
 Was the thread tapped? No Yes
 Was the enossal region covered completely by bone? No Yes
 Was a holding key used? No Yes
 Was primary stability achieved? No Yes
 Was osseointegration achieved? No Yes
 Was augmentation performed during surgery? No Yes
 if yes: Sinus lift Horizontal augmentation Material used: _____
 Was a membrane used? No Yes
 if yes: Absorbable Not absorbable Material used: _____

5. Information about the event

What was the hygienic status around the implant? Very good Good Average Poor

Were one or more of the following factors involved in the event?

Biomechanical overload Peri-implantitis Bone resorption Bruxism

Implant fracture Overheating of the bone Immediate implantation Infection

Nerve compression Trauma or accident Insufficient bone quality Sinus perforation

Prior bone graft Adjacent endodontically treated tooth

Other: _____

The following was observed at implant loss:

Abscess Numbness Increased sensitivity Fistula

Inflammation Hypersensitivity Pain Swelling

Instability Asymptomatic Bleeding

Had the implant already been prosthetically restored? Yes (please answer Point 6) No

What was the reason for implant loss in your opinion? _____

6. Information on the prosthetics

Type of restoration: Full prosthesis (max.) Partial prosthesis (max.) Crown Bridge

Full prosthesis (mand.) Partial prosthesis (mand.) Other: _____

When was the abutment placed? Date of final restoration

Date of temporary restoration Date of removal

Was a torque attachment used? Yes _____ Ncm No Not known

Were check-ups performed? Yes No

Case description: _____

7. Information in case of screw break *

REF Nr. Implant: LOT Nr. Implant: REF Nr. Abutment: LOT Nr. Abutment: Regio:

Date of screw breakage Date of remaining screw removal

Was a torque attachment used? Yes _____ Ncm No Not known

Type of restoration: _____

Case description: _____

8. Instruments

Approximate number of applications First time 2-5 6-10 > 10

Method of cleaning Manual Ultrasonic Thermal disinfectant

Method of sterilization Autoclaving Dry heat Chemical autoclaving

Which cleaning agent has been used: _____

9. Confirmation *

All returned products are to be autoclaved and labelled as "sterile".

Please add all the information necessary about the disputed products in this warranty form under consideration of the Hager & Meisinger GmbH warranty conditions and send this form including the autoclaved products and any X-rays back to Hager & Meisinger GmbH. Please use a padded bag for shipment - the loss of individual parts during shipment voids the warranty.

Date: _____

Signature of physician: _____



Hager & Meisinger GmbH

Hansemanstr. 10 | 41468 Neuss | Germany
 Tel.: +49 2131 2012-0 | Fax: +49 2131 2012-222
 Internet: www.meisinger.de | E-mail: info@meisinger.de