WARRANTY FORM

1. Customer information

Name of physician: _____ Customer number: _____

Address: _____ Telephone: _____

_____ Email: _____

_____ Documented by: _____

2. Product information

REF No.:	LOT No.:	Date inserted:	Date removed:	Regio:
		D D M M Y Y	D D M M Y Y	
		D D M M Y Y	D D M M Y Y	
		D D M M Y Y	D D M M Y Y	

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? _____

Was the thread tapped? ☐ Yes ☐ No

Was the enossal region covered completely by bone? ☐ Yes ☐ No

Was primary stability achieved? ☐ Yes ☐ No _____ Ncm

Was osseointegration achieved? ☐ Yes ☐ No

Was augmentation performed during surgery? ☐ Yes ☐ No Further information:

_____ Material used: _____

Was a membrane used? ☐ Yes ☐ No

☐ Absorbable ☐ Not absorbable Material used: _____

5. Information about the event

Hygienic status around the implant? ☐ Very good ☐ Good ☐ Average ☐ Poor

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

☐ Biomechanical overload ☐ Bruxism ☐ Bone resorption
☐ Implant fracture ☐ Peri-implantitis ☐ Infection
☐ Nerve compression ☐ Sinus perforation ☐ Immediate implantation
☐ Trauma or accident ☐ Overheating of the bone ☐ Insufficient bone quality
☐ Prior bone graft ☐ Adjacent endodontically treated tooth
☐ Other: _____

The following was observed at implant loss

☐ Abscess ☐ Asymptomatic ☐ Bleeding
☐ Inflammation ☐ Increased sensitivity ☐ Fistula
☐ Instability ☐ Pain ☐ Swelling
☐ Numbness ☐ Hypersensitivity

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

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

_____

6. Information on the prosthetics

Type of restoration ☐ Crown ☐ Bridge ☐ Partial prosthesis, maxillary ☐ Partial prosthesis, mandibular
☐ Full prosthesis, maxillary ☐ Full prosthesis, mandibular ☐ Other _____

When was the abutment placed? D D M M Y Y
Date of temporary restoration D D M M Y Y
Date of final restoration D D M M Y Y
Date of removal D D M M Y Y

Was a torque attachment used? ☐ Yes _____ Ncm ☐ No ☐ Not known
Were check-ups performed? ☐ Yes ☐ No

Case description: _____

_____

7. Instruments

Approximate number of applications ☐ First time ☐ 2-5 ☐ 6-10 ☐ >10
Method of cleaning ☐ Manual ☐ Ultrasonic ☐ Thermal disinfector
Method of sterilization ☐ Autoclaving ☐ Dry heat ☐ Chemical autoclaving

Brief description of the event: _____

_____

8. 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: _____