Please return item(s) **sterilized** and packed **separately!**

Dentsply Sirona Implants

Complaint Form

to be filled by selling location

Selling Location/ DI Division: _____

Complaint ref. no. of Selling Location/ DI Division: _____ **Complaint no:** _____

Customer / User

Customer ID _____

Name _____

Street _____

Address _____

Contact/ Phone _____

or Practice Stamp

Failed product (Implant, Component, Tool, etc.)

☐ Astra Tech Implant System ☐ Ankylos ☐ Frialit/ Xive ☐ _____

Name _____ Catalog no. _____ Lot no. _____ ☐ unknown

Concomitant product: _____

Event

Date of Event _____ - _____ - _____

☐ **No Primary Stability** ☐ **Implant Loss** ☐ **Fracture of Implant**

☐ **Other Surgical or Insertion Issue** (please describe below)

☐ **Abutment Fracture** ☐ **Screw Fracture** ☐ **Loosening** ☐ **Fit Issue**

☐ **Tool Issue** (please describe below)

☐ **Other** (please describe below)

Additional Information/ Description

_____

_____

_____

_____

Position:

	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R																L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Dentsply Sirona Implants

Patient Information Name or Identifier _____ Date of Birth _____ - _____ - _____ Sex ☐♂ ☐♀

Oral Hygiene ☐ excellent ☐ fair ☐ poor

Bone Quality ☐ I ☐ II ☐ III ☐ IV

Medical History ☐ Smoker ☐ Diabetes ☐ Bruxism

Chewing/ Bite Habits _____

Others _____

Date of

Implant placement _____ - _____ - _____ Immediate Impl. Placement ☐ yes ☐ no

Loss/ explantation _____ - _____ - _____ Immediate Loading ☐ yes ☐ no

Prosthetic Restoration _____ - _____ - _____ Type of abutment _____

Time of Implant Loss/ Explantation ☐ Healing Period ☐ Re-entry ☐ Prior to Functional Loading ☐ After Functional Loading

Healing ☐ Subgingival ☐ Transgingival

Augmentation ☐ Preoperative ☐ At Time of Implant Placement ☐ None

Grafting Materials _____

Implant Site Preparation

☐ Bone Condensing ☐ Bone Expanding ☐ Bone Spreading

☐ Drilling ☐ Thread Cutter Others _____

Diagnostic Findings before Explantation

☐ Infection ☐ Mobility ☐ Osteolysis

☐ Occlusal Overload ☐ Progressive Bone Loss ☐ Periimplantitis

Prosthetic Treatment

☐ Cemented ☐ Complete Denture ☐ Only Implant supported ☐ Removable Bridge

☐ Fixed Bridge ☐ Fixed Partial Denture ☐ Removable Partial Denture ☐ Screw Retained

☐ Implant/ Tooth supported ☐ Single Tooth

Additional Comments _____

☐ Item enclosed ☐ other attachments _____

☐ Item will be sent subsequently _____

☐ Item won't be returned because _____

Date _____ - _____ - _____ **Signature** _____