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** Identifier _____

**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** _____