Guarantee Questionnaire

MEDENTiKA®
A Straumann Group Brand

1. CUSTOMER INFORMATION

Customers's Name

Customer Account

Address

Telephone

Country

Reported by

2. PRODUCT INFORMATION (Please list all involved MEDENTiKA® Products)

Article Number	LOT Number	Placement Date (D/M/Y)	Removal/Event Date (D/M/Y)	Regio

3. GENERAL PATIENT INFORMATION

Patient ID No* Age ☐ Female ☐ Male

*For data privacy reasons DO NOT insert patient's name

Medical Record:

☐ Diabetes Mellitus
☐ Radiation Tx-head/neck area
☐ Illness requiring steroids
☐ Chemotherapy around time of implant placement
☐ Psychological disorder
☐ Xerostomia
☐ Lymphatic disorder
☐ Uncontrolled endocrine illness
☐ Compromised immuno resistance
☐ Blood coagulation disorder
☐ Drug or alcohol abuse

Allergies: _____

Other local or systemic diseases which may be significant: _____

Does the patient smoke? ☐ Yes ☐ No ☐ No significant findings

4. SURGICAL INFORMATION (Only required with implant complaints)

☐ Manual placement ☐ Handpiece adapter

If implant was placed and removed the same day, was another implant successfully placed in the site during surgery?

☐ Yes ☐ No

Any problems with:

☐ Implant insertion into bone
☐ Removal of implant from vial
☐ Removal of device from implant

Other: _____

At the time of surgery, were any of the following present:

☐ Periodontal disease
☐ Local infection/subacute chronic osteitis
☐ Diseased mucous membrane
☐ Complication in site preparation

Bone quality	☐ D I	☐ D II	☐ D III	☐ D IV
Was the site tapped?	☐ Yes	☐ No	☐ N/A	
Holding Key used	☐ Yes	☐ No	☐ N/A	
Was primary stability achieved?	☐ Yes	☐ No		
Did implant achieve osseointegration?	☐ Yes	☐ No		
Was the implant surface completely covered with bone?	☐ Yes	☐ No		

Was augmentation performed at the time of surgery?

☐ No ☐ Sinus ☐ Ridge

Material used: _____

Was GTR membrane used?

☐ No ☐ Yes ☐ Resorbable ☐ Non-resorbable

Material used: _____

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5. EVENT INFORMATION (Only required with implant complaints)

Hygiene around implant ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Were any of the following involved in the event?

☐ Trauma/Accident ☐ Implant fracture ☐ Inadequate bone quality/quantity
☐ Biomechanical overload ☐ Overheating of bone ☐ Previous bone augmentation
☐ Immediate extraction site ☐ Peri-implantitis ☐ Nerve encroachment
☐ Adjacent to endodontic tooth ☐ Infection ☐ Sinus perforation
☐ Tongue (pressure) ☐ Bruxism ☐ Bone resorption

Other: _____

At the time of implant failure, there was (check all that apply):

☐ Pain ☐ Bleeding ☐ Swelling ☐ Numbness
☐ Mobility ☐ Fistula ☐ Asymptomatic ☐ Inflammation
☐ Hypersensitivity ☐ Increased sensitivity ☐ Abscess Other: _____

Was the prosthesis fitted? ☐ No ☐ Yes If yes, please complete section 6.

If the implant is not being removed, is there evidence of the following (check all that apply)?

Extent (mm): Bone Loss _____ Dehiscence _____ Peri-implantitis _____ Fenestration_____ Other_____

Please comment on why you think the implant failed/was removed:

_____

_____

6. PROSTHESIS INFORMATION (Only required for prosthetic complaints)

CADCAM Project no.: _____ ☐ Model ☐ Insertion ☐ In use

Type of restoration? ☐ Crown ☐ Bridge ☐ RPD (upper) ☐ RPD (lower)
☐ Full (upper) ☐ Full (lower) Other: _____

Date abutment was installed ☐☐ ☐☐ ☐☐☐☐ Date of abutment removal (D/M/Y) ☐☐ ☐☐ ☐☐☐☐

Torque Control Device used? ☐ Yes ☐ No ☐ Unknown

Torque applied ☐☐ Ncm

Date of temporary restoration installation ☐☐ ☐☐ ☐☐☐☐ Date of final restoration installation ☐☐ ☐☐ ☐☐☐☐

Was the recall appointment schedule followed ☐ Yes ☐ No

☐ Abutment fracture ☐ Screwfracture ☐ Surface abrasion

Other:

_____

_____

7. INSTRUMENTS (Only required for instrument complaints)

Approximate number of uses: ☐ initial use ☐ 2–5 ☐ 6–10 ☐ 10–15 ☐ more than 15
(Cutting instruments only)

Type of cleaning method used ☐ Manual ☐ Ultrasonic ☐ Thermodisinfection Other: _____

Type of sterilization method used ☐ Autoclave ☐ Dry heat

Short description of incident:

_____

_____

Please return questionnaire, autoclaved product and include X-rays (as appropriate). Use a padded pouch to return items – failure to do so could result in items lost during shipment and void guarantee program. Autoclave all products and label them as sterile.

Please note that your data will be transferred to Institut Straumann AG, Basel, Switzerland but may also be transferred for further investigations to the countries where the respective manufacturer of the product is domiciled. This may include countries outside the European Union for which there is no European Commission decision that they ensure an adequate level of protection for personal data.

Doctor's Signature:_____ Date:_____

For internal use only

☐ CSN ☐ PSO ☐ ASR ☐ RPC ☐ Info incomplete ☐ Std/No