DENTAL RATIO
Dental Implant System

Warranty Form

Customer Information

Clinician's Name _____ Customer Account _____

_____ _____

Adress _____ Telephone _____

_____ Country _____

Reported by _____

Product Information (Please list all involved DENTAL RATIO Products)

Article Number	LOT Number	Placement Day (DD/MM/YYYY)	Removal Day (DD/MM/YYYY)	Position

General Patient Information (complete this section only, if returning implants)

Patient ID No. * _____ Age ____ ☐ F ☐ M

* For privacy reasons do NOT enter the name of the patient

Medical Record

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

Allergies _____

Other local or systemic diseases which may be significant? _____

Smoker ☐ Yes ____ cigarettes/day ☐ No ☐ No significant findings

Implant Failure - Surgical Information (complete this section only, if returning implants)

☐ Manuel Placement ☐ with Handpiece Adapter

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

☐ Yes ☐ No

If you experienced difficulty with inserting device/pre-mounted transfer part this occured upon?

☐ Implant insertion ☐ Removal of device from implant ☐ Removal of implant from vial ☐ Other _____

Have there been present any diseases when placing the implants?

☐ Periodontal disease ☐ Diseased mucous membrane ☐ Local Infection/Subacute Chronic Osteitis ☐ Complication in site preparation

Quality of bone	☐ Type D1	☐ Type D2	☐ Type D3	☐ Type D4
Site tapped?	☐ Yes	☐ No	☐ Not applicable	
Profile drill used?	☐ Yes	☐ No	☐ Not applicable	
Holding key used?	☐ Yes	☐ No	☐ Not applicable	
Primary stability achieved?	☐ Yes	☐ No		
Osseointegration of implant achieved?	☐ Yes	☐ No		
Implant surface completely covered with bone?	☐ Yes	☐ No		

Augmentation at the time of surgery?

☐ No ☐ Sinus ☐ Ridge Material used: _____

GTR membrane?

☐ No ☐ Yes ☐ Resorbable ☐ Non-resorbable

Material used: _____

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General Information (complete this section only, if returning implant)

Hygiene around implant ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Other circumstances?

☐ Trauma/Accident
☐ Biomechanical Overload
☐ Immediate Extraction Site
☐ Adjacent to Endotontic Tooth
☐ Tongue (Pressure)
☐ Implant Fracture
☐ Overheating of bone
☐ Peri-Implantitis
☐ Infection
☐ Bruxism
☐ Inadequate Bone Quality/Quantity
☐ Previous Bone Augmentation
☐ Nerve Encroachment
☐ Sinus Perforation
☐ Bone Resorption

When the implant failed there had been (check all that apply)

☐ Pain ☐ Bleeding ☐ Swelling ☐ Numbness
☐ Mobility ☐ Fistula ☐ Asymptomatic ☐ Inflammation
☐ Increased Sensitivity ☐ Hypertension ☐ Abscess ☐ Others: _____

The Prosthesis has been fitted? ☐ No ☐ Yes, please complete Section Prosthesis

If the implant isn't removed: Are there any indications of the following? (please tick the appropriate box)

Expansion (mm): Bone loss _____ Dehiscence _____ Peri-Implantitis _____ Fenestration _____ Others _____

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

_____

_____

Prosthesis Information (complete this section only, if returning abutments and restorations)

☐ Model ☐ Therapy ☐ in use

Type of restoration? ☐ Crown ☐ Bridge ☐ RPD (upper) ☐ RPD (lower)
☐ Full (upper) ☐ Full (lower) ☐ Telescope ☐ Others _____

Abutment inserted (date) ☐☐ ☐☐ ☐☐☐☐ Abutment removed (date) ☐☐ ☐☐ ☐☐☐☐

Torque control device used? ☐ Yes ☐ No ☐ Unknown Torque applied: ☐☐ Ncm

Temporary restoration (date of insertion) ☐☐ ☐☐ ☐☐☐☐ Final restoration (date of insertion) ☐☐ ☐☐ ☐☐☐☐

Did the patient follow recall instructions? ☐ Ja ☐ Nein

Comment:

_____

_____

Instruments (complete this section only, if returning instruments)

Approximate number of uses (Cutting Instruments only) ☐ Initial use ☐ 2 - 5 ☐ 6 - 10 ☐ 11 - 15 ☐ over 15

Type of cleaning method ☐ Manual ☐ Ultrasonic ☐ Thermodesinfection ☐ Others: _____

Type of sterilization method ☐ Autoclave ☐ Dry heat ☐ Chemiclav

Short description of incident:

_____

_____

Please return this questionnaire, the sterilized product and include X-Rays (as appropriate).
Use a padded pouch to return items - not to follow this recommendation may result in items getting lost during shipment volding this guarantee program.
Autoclave all return products and label them as sterile.
Based on the DRS Guarantee Terms and Conditions, please consider replacing the above listed products.

Signature: _____ Date: _____

* When the patient ID is not anonymised in the form (and additional attachments) and contains personal information, the patient has to give a written consent.