medical instinct®
... WE ARE IMPLANTOLOGY!

DOCUMENTATION SHEET IMPLANTOLOGY

Your information is important! In order to permanently guarantee and improve the safety of our medical products, we need your support.
Please fill out this form completely, otherwise we cannot process your complaint!

Information on the attending physician:

☐ Dentist ☐ Oral Surgeon ☐ OMS

Address: _____

_____

Customer number: _____

Contact: _____

Phone: _____

Nature of the incident:

☐ missing primary stability ☐ implant not osseointegrated ☐ implant fracture

☐ other complaint: _____

When experiencing a implant fracture please send a x-ray with the prosthetics in situ.

Implant / article:

regio: _____ article number: _____ batch-/lot number: _____

regio: _____ article number: _____ batch-/lot number: _____

regio: _____ article number: _____ batch-/lot number: _____

regio: _____ article number: _____ batch-/lot number: _____

Information about the patient:

☐ f ☐ m patient-ID: _____ age: _____

Date of inseration : _____ Date of loss: _____

Set implants: _____ Lost implants: _____

Patient history:

Oral hygiene: ☐ good ☐ average ☐ bad

☐ alcohol ☐ smoker ☐ diabetes ☐ bruxism ☐ radiation therapy head and neck area

☐ chemotherapy at the time of implantation ☐ mental disorders ☐ compromized immune resistance ☐ bleeding disorder

☐ allergies _____ ☐ other diseases_____

Bone quality: ☐ Typ I ☐ Typ II ☐ Typ III ☐ Typ IV Was a threader used? ☐ yes ☐ no

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Augmentation:

☐ preoperatively (____weeks) ☐ simultaneous ☐ autologous bone ☐ no augmentation

☐ bone substitute material: _____ ☐ membrane: _____

Implantation:

☐ immediate implant ☐ delayed implantation after _____ weeks ☐ late implantation

☐ immediate restorations ☐ immediate loading

Prosthetic restoration:

☐ yes Date:_____

☐ single crown ☐ bridge _____-linked ☐ splinted crowns ☐ telescopic ☐ bar restoration ☐ Lucky Lock restoration

☐ no

If the implant was lost, the following was found:

☐ pain ☐ bleeding ☐ swelling ☐ deafness

☐ instability ☐ fistula ☐ asymptomatic ☐ inflammation

☐ hypersensitivity ☐ abscess ☐ other: _____

How and for what reason do you think the incident happened?

_____

_____

_____

Please let us know which implant or prosthetic component you would like to replace:

article number: _____

Date: _____ Signature: _____

For internal use only:

date of receipt: _____ case report no.: _____ invoice no.: _____

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YOUR SHIPPING LABEL

Please use the shipping label below, otherwise the delivery will not can be edited and must be destroyed.

Your and our safety is important to us!

Therefore, please seal the cleaned items in suitable foil, sterilize them and send them to us - be sure to pack them in a padded envelope / package
Medical Instinct® Deutschland GmbH, Graseweg 24, 37120 Bovenden, Germany.

Sender

_____

_____

_____

_____

Please add suffcient postage

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