medical ins+inct®
... 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: ______ art-no.: _________________ batch/lot-no.: _________________ rpm: _______ Ncm: _______

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Instruments and tools:

Which drill was finally used: ___________________

Approximate number of uses (only for cutting instruments):
☐ first time use ☐ 2-5 ☐ 6-10 ☐ 11-15 ☐ more than 15

Information about the patient:

☐ f ☐ m patient-ID: ____ age: _____

Date of inseration : ____________________________ Date of loss: ____

Set implants: ________________________________ Lost implants: ____

Patient history:

Oral hygiene: ☐ good ☐ avarage ☐ bad

☐ no contraindication ☐ 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

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 ☐ interim implants used

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: ____

Has the patient suffered any health problems? ☐ yes ☐ no

If so, in which form ____

____

Initiated medical aftercare ____

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

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