

Please return  
item(s) sterilized

## Simplant Complaint registry form



### To be filled in by selling location

Selling location:

Contact person in Location/ DSD

TrackWise Complaint no.:

Date of filing complaint:

### Customer/user

Customer ID:

Name:

Address line 1:

Address line 2:

E-mail:

Contact/Phone:

### Failed product

Order ID/ Serial:

Patient reference:

Guide type:

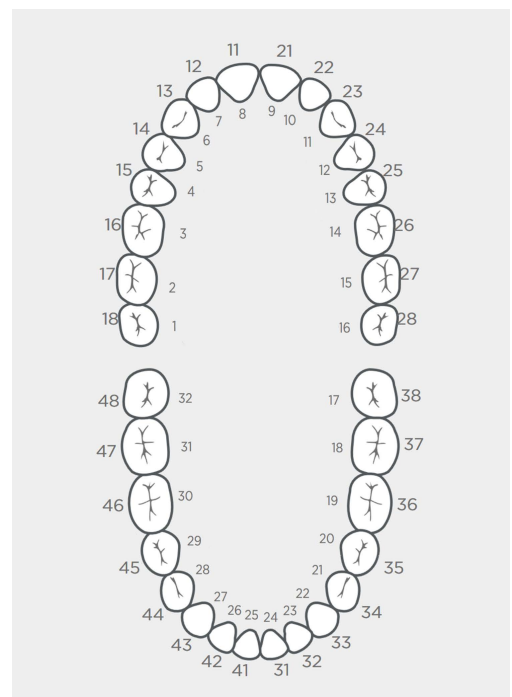
Immediate Smile:

Wafer:

Reduction Guide:

Other involved products:

### Failed implant position(s)



### Patient harm due to failing product

- A neighboring tooth has been damaged or hit by an implant
- The implant fenestrated the cortical wall
- A nerve was hit

## Classify the problem

- Implant transfer for implant(s) position:
- |                                     |                                      |                                      |
|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Too deep   | <input type="checkbox"/> Too shallow | <input type="checkbox"/> Too mesial  |
| <input type="checkbox"/> Too distal | <input type="checkbox"/> Too buccal  | <input type="checkbox"/> Too lingual |
- Guide broke
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> During shipment | <input type="checkbox"/> Before surgery | <input type="checkbox"/> During surgery |
|--|---|---|
- Bad fit
- |   |  |
|---|--|
| <input type="checkbox"/> Only in patient's mouth              |  |
| <input type="checkbox"/> Both on model and in patient's mouth |  |
- Brand and type of the (CB)CT scanner:
- Brand and type of the optical scanner:
- Other
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Drill protocol issue      | <input type="checkbox"/> Tooth extraction    | <input type="checkbox"/> Wrong supporting surface    |
| <input type="checkbox"/> Missing/incorrect tube(s) | <input type="checkbox"/> Communication issue | <input type="checkbox"/> Special design not followed |
- Post-op scan data or other images available?       Yes     No

## Event

## Date of event:

The sterilization was performed according to the Instructions For Use:

- Yes       No

The surgery was performed in accordance to the surgical guidelines (drilling protocol):

- Yes       No

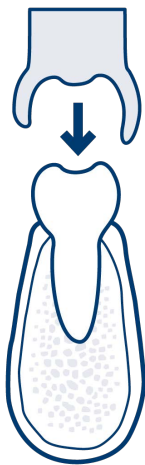
Describe product failure and patient's current situation. Please describe the issue as detailed and thorough as possible. We need to know if the surgery was performed with or without the guide, was the issue discovered before, during or after the surgery. Mention specifically which implants (if any) are part of the issue. What is the current situation of the patient? In order to investigate the issue we need you to be as specific and detailed as possible.

Additional pictures in order to explain product failure:

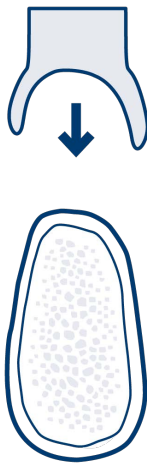
### Remake request

If the patient is scheduled for a new treatment which requires a new Siplant Guide, please fill out the questionnaire below.

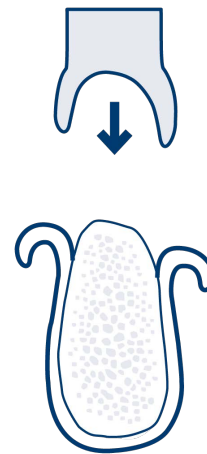
Surgery type:



Tooth supported guide



Mucosa supported guide



Bone supported guide

Other, Please specify below

Guide type:

Siplant Pilot Guide

Siplant Universal Guide

Siplant SAFE Guide

Other, Please specify below

Specific remarks regarding the remake:

# Versandetikett

**Absender**

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Bitte  
ausreichend  
frankieren

**Dentsply Sirona Deutschland GmbH  
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