Please return item(s) **sterilized** and packed **separately!**

Complaint Form

The fields marked with an * are **required**!

to be filled by selling location

Selling Location/ DI Division: _____

Complaint ref. no. of Selling Location/ DI Division: _____ Complaint no: _____

Use Practice Stamp

or

Practice/Dentist

DentsplySirona accountnumber _____

Name _____

Street _____

Adress _____

Contact/Phone _____

Failed product * (choose at least one! Implant, Component, Tool etc.)

☐ Astra Tech Implant System ☐ MIS ☐ Ankylos ☐ Frialit/ Xive ☐ _____

Name _____ Catalog no. _____ Lot no. _____ ☐ unknown

Concomitant product: _____

Event * (choose at least one event!)

Date of Event* ___ - ___ - ___

☐ No Primary Stability ☐ Implant Loss ☐ Fracture of Implant

☐ Other Surgical or Insertion Issue (please describe below)

☐ Abutment Fracture ☐ Screw Fracture ☐ Loosening ☐ Fit Issue

☐ Tool Issue (please describe below)

☐ Other (please describe below)

Additional Information/ Description

Position* (mandatory to choose **at least 1 position**)

	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R																L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Dentsply Sirona Implants

Patient Identifier* _____

Oral Hygiene ☐ excellent ☐ fair ☐ poor

Bone Quality ☐ I ☐ II ☐ III ☐ IV

Medical History ☐ Smoker ☐ Diabetes ☐ Bruxism

Chewing/ Bite Habits _____

Others _____

Date of

Implant placement* ____ - ____ - ____ Immediate Impl. Placement ☐ yes ☐ no

Loss/ explantation* ____ - ____ - ____ Immediate Loading ☐ yes ☐ no

Prosthetic Restoration ____ - ____ - ____ Type of abutment _____

Time of Implant Loss/ Explantation ☐ Healing Period ☐ Re-entry ☐ Prior to Functional Loading ☐ After Functional Loading

Healing ☐ Subgingival ☐ Transgingival

Augmentation ☐ Preoperative ☐ At Time of Implant Placement ☐ None

Grafting Materials _____

Implant Site Preparation ☐ Bone Condensing ☐ Bone Expanding ☐ Bone Spreading

☐ Drilling ☐ Thread Cutter Others _____

Diagnostic Findings before Explantation ☐ Infection ☐ Mobility ☐ Osteolysis

☐ Occlusal Overload ☐ Progressive Bone Loss ☐ Periimplantitis

Prosthetic Treatment ☐ Cemented ☐ Complete Denture ☐ Only Implant supported ☐ Removable Bridge

☐ Fixed Bridge ☐ Fixed Partial Denture ☐ Removable Partial Denture ☐ Screw Retained

☐ Implant/ Tooth supported ☐ Single Tooth

Additional Comments

☐ Item enclosed ☐ other attachments _____

☐ Item will be sent subsequently _____

☐ Item won't be returned because _____

Date* _____ - _____ - _____ **Signature***