myplant

In case of a screw break, please only fill in sections marked with *

WARRANTY FORM
Implantology

1. Customer information *

Name of physician: _____ Customer No.: _____

Address: _____ Telephone: _____

_____ Email: _____

_____ Documented by: _____

2. Product information *

REF No. Implant:	LOT No. Implant:	Date inserted:	Date removed:	Regio:
		D D M M Y Y	D D M M Y Y	
		D D M M Y Y	D D M M Y Y	
		D D M M Y Y	D D M M Y Y	

3. Patient information

Patient ID: _____ Age: _____ ☐ F ☐ M

Bone density ☐ D1 ☐ D2 ☐ D3 ☐ D4 Smoker? ☐ No ☐ Yes

Medical history:

☐ Alcohol or drug abuse ☐ Blood coagulation disorder ☐ Chemotherapy during implantation

☐ Diabetes mellitus ☐ Compromised immune resistance ☐ Treatment with corticosteroids

☐ Lymphatic disorder ☐ Untreated endocrine disorders ☐ Psychic disorders

☐ Xerostomy ☐ Radiation therapy in head/neck region ☐ No relevant findings

☐ Immunological disorders ☐ Known allergies: _____

☐ Other relevant disorders: _____

4. Surgical information

If the implant was inserted and removed on the same day, was another implant inserted successfully in the same place? ☐ No ☐ Yes LOT: _____

How was the implant inserted? ☐ Hand wheel ☐ Ratchet ☐ Angled handpiece Torque: _____ Ncm

Did problems occur with the pre-mounted transfer part? ☐ No ☐ Yes _____

Was one of the following points evident at the time of the intervention? ☐ Complication during preparation of the implant bed

☐ Periodontal disease ☐ Mucosal disease ☐ Local infection / subacute chronic osteitis

What was the maximum speed employed during preparation? min^{-1}

Which drill was used last? _____ Ø _____ mm

Was the thread tapped? ☐ No ☐ Yes

Was the enossal region covered completely by bone? ☐ No ☐ Yes

Was a holding key used? ☐ No ☐ Yes

Was primary stability achieved? ☐ No ☐ Yes _____ Ncm

Was osseointegration achieved? ☐ No ☐ Yes

Was augmentation performed during surgery? ☐ No ☐ Yes

if yes: ☐ Sinus lift ☐ Horizontal augmentation Material used: _____

Was a membrane used? ☐ No ☐ Yes

if yes: ☐ Absorbable ☐ Not absorbable Material used: _____

5. Information about the event

What was the hygienic status around the implant? ☐ Very good ☐ Good ☐ Average ☐ Poor

Were one or more of the following factors involved in the event?

☐ Biomechanical overload ☐ Peri-implantitis ☐ Bone resorption ☐ Bruxism
☐ Implant fracture ☐ Overheating of the bone ☐ Immediate implantation ☐ Infection
☐ Nerve compression ☐ Trauma or accident ☐ Insufficient bone quality ☐ Sinus perforation
☐ Prior bone graft ☐ Adjacent endodontically treated tooth
☐ Other: _____

The following was observed at implant loss

☐ Abscess ☐ Numbness ☐ Increased sensitivity ☐ Fistula
☐ Inflammation ☐ Hypersensitivity ☐ Pain ☐ Swelling
☐ Instability ☐ Asymptomatic ☐ Bleeding

Had the implant already been prosthetically restored? ☐ Yes (please answer point 6) ☐ No

What was the reason for implant loss in your opinion? _____

_____

6. Information on the prosthetics

Type of restoration: ☐ Full prosthesis (max.) ☐ Partial prosthesis (max.) ☐ Crown ☐ Bridge
☐ Full prosthesis (mand.) ☐ Partial prosthesis (mand.) ☐ Other: _____

REF No. prosthetics: _____ LOT No. prosthetics: _____

When was the abutment placed? D D M M Y Y Date of final restoration D D M M Y Y

Date of temporary restoration D D M M Y Y Date of removal D D M M Y Y

Was a torque attachment used? ☐ Yes _____ Ncm ☐ No ☐ Not known

Were check-ups performed? ☐ Yes ☐ No

Case description: _____

_____

7. Information in case of screw break *

REF No. Abutment: _____ LOT No. Abutment: _____ Date of screw breakage: D D M M Y Y Date of remaining screw removal: D D M M Y Y

Was a torque attachment used? ☐ Yes _____ Ncm ☐ No ☐ Not known

Type of restoration: _____

Case description: _____

_____

8. Instruments

Approximate number of applications ☐ First time ☐ 2-5 ☐ 6-10 ☐ >10

Method of cleaning ☐ Manual ☐ Ultrasonic ☐ Thermal disinfector

Method of sterilization ☐ Autoclaving ☐ Dry heat ☐ Chemical autoclaving

Which cleaning agent has been used: _____

_____

9. Confirmation *

All returned products are to be autoclaved and labelled as "sterile".

Please add all the information necessary about the disputed products in this warranty form under consideration of the Hager & Meisinger GmbH warranty conditions and send this form including the autoclaved products and any X-rays back to Hager & Meisinger GmbH. Please use a padded bag for shipment - the loss of individual parts during shipment voids the warranty.

Date: _____

Signature of physician: _____

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