

COMPLAINTS QUESTIONNAIRE

- Please complete this form as detailed as possible. Missing information may delay the processing.
- Please also return the explanted product(s) in a sterilized condition.
- Please return implants without abutments, since we can not remove them for you.

A. Customer Information		
Customer No.		Practice Stamp
Name of Practice/Clinic		
Email-Address		
Country		

B. Product Information	
Product type <input type="radio"/> Implant <input type="radio"/> Prosthetics <input type="radio"/> Instrument	Article-No. Charge/LOT

C. Patient Information		
Patient-ID		Health condition prior to surgery <input type="radio"/> Smoker <input type="radio"/> No significant <input type="radio"/> Bruxism <input type="radio"/> Marcumar <input type="radio"/> Diabetic <input type="radio"/> Other _____
Age	<input type="radio"/> <20 <input type="radio"/> 20-50 <input type="radio"/> 50-70 <input type="radio"/> >70	
Bone type	<input type="radio"/> T1 <input type="radio"/> T2 <input type="radio"/> T3 <input type="radio"/> T4	
Tooth-No.		

D. Surgery Information	
Date of Implantation __/__/____	Date of prosthetic treatment __/__/____
Surgery Information <input type="radio"/> cleaned, disinfected and sterilized prior to use <input type="radio"/> Applied bone augmentation procedure Instruments <input type="radio"/> Other _____	

E. Information about incident	
Date of incident __/__/____	
Oral hygienic situation at implant site <input type="radio"/> Excellent <input type="radio"/> Good <input type="radio"/> Average <input type="radio"/> Poor	Patient symptoms <input type="radio"/> Pain <input type="radio"/> Dehiscence <input type="radio"/> Infection <input type="radio"/> Bone loss <input type="radio"/> Swelling <input type="radio"/> Other _____ <input type="radio"/> Nerve damage _____

Description of events <input type="radio"/> No primary stability <input type="radio"/> Problems during handling <input type="radio"/> No osseointegration <input type="radio"/> Other _____ <input type="radio"/> Mechanical malfunctioning of product _____	Was the patient able to be successfully re-treated: <input type="radio"/> Yes <input type="radio"/> No
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Please describe why, in your opinion, it resulted in implant loss or why the implant had to be removed:

Please send the completed form together with the explanted and sterilized product(s) to: TRI® Dental Implants z. H.: Complaint Handling Merzhäuserstraße 183 79100 Freiburg/Germany	For questions E-Mail: complaints@tri-implants.swiss Fax: +41 32 510 1601 Phone: 00800 3313 3313	For returns from the USA, please use the following address: May Dental Arts 515 Mae Court Fenton, MO 63026 USA	For questions E-Mail: complaints@tri-implants.swiss Infoline USA Tollfree: (636) 486-7334
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Date	Signature
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