Guarantee form

As specified in paragraph 8 of the Thommen Medical Guarantee, all applicable data protection regulations must be complied with and all patient data must be anonymized. A patient ID number, which does not allow any conclusions to be drawn about patient data, must be used for each patient.

1. CUSTOMER INFORMATION

Attending physician's name and address (use capital letters or stamp)

_____ Telephone _____

_____ Country _____

_____ Contact at the practice _____

_____

_____

2. PRODUCT INFORMATION (please list all Thommen Medical products involved)

Art. no.	Lot no.	Placement Date (D/M/Y)	Removal Date (D/M/Y)	Region
___ . _____ . _____	_____	_____ / _____ / _____	_____ / _____ / _____	_____
___ . _____ . _____	_____	_____ / _____ / _____	_____ / _____ / _____	_____
___ . _____ . _____	_____	_____ / _____ / _____	_____ / _____ / _____	_____
___ . _____ . _____	_____	_____ / _____ / _____	_____ / _____ / _____	_____

Date of the event: _____ / _____ / _____

3. GENERAL PATIENT INFORMATION (complete this section only if returning implants)

Patient ID no. _____ Age: _____ ☐ Female ☐ Male

Medical Record

☐ Radiation Tx-head/neck area
☐ Bisphosphonate treatment
☐ Illness requiring steroids
☐ Chemotherapy around time of implant placement
☐ Blood coagulation disorder
☐ Compromised immune resistance
☐ Diabetes mellitus
☐ Uncontrolled endocrine illness
☐ Psychological disorder
☐ Drug or alcohol abuse
☐ Xerostomia
Smoker: ☐ Yes ☐ No

Other local or systemic diseases which may be significant: _____

Allergies: _____ ☐ No significant findings

4. INFORMATION (complete this section only if returning implants)

☐ Manual placement ☐ Mechanical insertion

Comments (use capital letters): _____

If implant was placed and removed the same day, was another implant successfully placed in the site during surgery? ☐ Yes ☐ No

At the time of surgery, were any of the following present:

☐ Periodontal disease
☐ Diseased mucous membrane
☐ Local infection/ subacute chronic osteitis
☐ Complication in site preparation
Whichever: _____

Bone quality ☐ Type I ☐ Type II ☐ Type III ☐ Type IV
Use thread tap? ☐ Yes ☐ No
Was primary stability achieved? ☐ Yes ☐ No
Did implant achieve osseointegration? ☐ Yes ☐ No
Was the implant surface completely covered with bone? ☐ Yes ☐ No

Was augmentation performed at the time of surgery?

☐ No ☐ Sinus ☐ Ridge Material used: _____

Was GTR membrane used?

☐ No ☐ Yes ☐ Resorbable ☐ Non-resorbable Material used: _____

5. EVENT INFORMATION (complete this section only if returning implants)

Hygiene around implant ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Were any of the following involved in the event?

☐ Trauma/Accident
☐ Biomechanical overload
☐ Bruxism
☐ Implant fracture
☐ Immediate implantation
☐ Undersized implant bed
☐ Overheating of bone
☐ Nerve encroachment
☐ Sinus perforation
☐ Inadequate bone quality/quantity
☐ Preceding/simultaneous bone augmentation
☐ Bone resorption
☐ Peri-Implantitis
☐ Infection

Other (please write in capital letters): _____

At the time of implant failure, there was (check all that apply):

☐ Pain ☐ Swelling ☐ Bleeding ☐ Mobility
☐ Numbness ☐ Fistula ☐ Inflammation Other: _____
☐ Increased sensitivity ☐ Abscess ☐ Asymptomatic

Was the prosthesis fitted? ☐ Yes ☐ No **If yes, please complete section 6.**

Please comment on why you think the implant failed/was removed (please write in capital letters):

_____

_____

6. PROSTHESIS INFORMATION (complete this section only if returning abutments and restorations)

☐ Model ☐ Insertion ☐ In use

Type of restoration? ☐ Crown ☐ Bridge RPD: ☐ Upper ☐ Lower
Full: ☐ Upper ☐ Lower

Date abutment was installed? ____ / ____ / _____ (D/M/Y)
Date of abutment removal: ____ / ____ / _____ (D/M/Y)

Was the MONO torque ratchet used? ☐ Yes ☐ No ☐ Unknown Torque applied: ____ Ncm

Date of temporary restoration installation: ____ / ____ / _____ (D/M/Y)
Date of final restoration installation: ____ / ____ / _____ (D/M/Y)

Was a check-up performed? ☐ Yes ☐ No

Description of event (please write in capital letters):

_____

_____

7. INSTRUMENTS (complete this section only if returning instruments)

Which drills were used: ☐ VECTOdrill steel ☐ VECTOdrill ceramic

☐ Other Whichever: _____

Approximate number of uses (cutting instruments only): ☐ Initial use ☐ 2-5 x ☐ 6-10 x ☐ 10-20 x ☐ More than 20 x

Type of cleaning method used: ☐ Manual ☐ Ultrasonic ☐ Thermodesinfection Other: _____

Type of sterilization method used: ☐ Autoclave ☐ Dry heat ☐ Chemiclave

Short description of incident (please write in capital letters):

_____

_____

Please return questionnaire, autoclaved product and include X-rays (as appropriate) to your distribution partner.
Use a padded pouch to return items – failure to do so could result in items lost during shipment and void guarantee program.
Autoclave all products (do not clean) and lable them as **sterile.**

Based on the Thommen Medical Guarantee Terms and Conditions, please consider replacing the above listed products.

Doctor's Signature: _____ Date: _____

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