GUARANTEE FORM

1. CUSTOMER INFORMATION

Clinician's Name

Address

Customer Account #

Telephone

Country

Reported by

2. PRODUCT INFORMATION (Please list all involved Straumann Products)

Article Number	LOT Number	Placement Date (D/M/Y)	Removal Date (D/M/Y)	Region

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

Patient ID No

Age

☐ Female ☐ Male

Medical Record:

☐ Diabetes Mellitus
☐ Radiation Tx-head/neck area
☐ Illness requiring steroids
☐ Chemotherapy around time of implant placement
☐ Psychological disorder
☐ Xerostomia
☐ Lymphatic disorder
☐ Drug or alcohol abuse
☐ Uncontrolled endocrine illness
☐ Compromised immuno resistance
☐ Blood coagulation disorder

Allergies: _____

Other local or systemic diseases which may be significant: _____

Does the patient smoke? ☐ Yes ☐ No

☐ No significant findings

4. SURGICAL INFORMATION (Complete this section only if returning implants)

☐ Manual placement ☐ Handpiece adapter

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

If you experienced difficulty with inserting device/pre-mounted transfer part this occurred upon:

☐ Implant insertion into bone
☐ Removal of implant from vial
☐ Removal of device from implant
Other: _____

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

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

Bone quality	☐ Type I	☐ Type II	☐ Type III	☐ Type IV
Was the site tapped?	☐ Yes	☐ No	☐ N/A	
Holding key used	☐ Yes	☐ No	☐ N/A	
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
☐ Immediate extraction site
☐ Adjacent to endodontic tooth
☐ Tongue (pressure)
☐ Implant fracture
☐ Overheating of bone
☐ Peri-implantitis
☐ Infection
☐ Bruxism
☐ Inadequate bone quality/quantity
☐ Previous bone augmentation
☐ Nerve encroachment
☐ Sinus perforation
☐ Bone resorption

Other: _____

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

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

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

Please comment on why you think the implant failed/was removed:

_____

_____

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

Project no.: _____

Type of restoration? ☐ Crown ☐ Full (upper) ☐ Model ☐ Bridge ☐ Full (lower) ☐ Insertion ☐ RPD (upper) ☐ In use ☐ RPD (lower) Other: _____

Date abutment was installed ☐☐ ☐☐ ☐☐☐☐ Date of abutment removal (D/M/Y) ☐☐ ☐☐ ☐☐☐☐

Torque control device used? ☐ Yes ☐ No ☐ Unknown

Torque applied ☐☐ Ncm

Date of temporary restoration installation ☐☐ ☐☐ ☐☐☐☐ Date of final restoration installation ☐☐ ☐☐ ☐☐☐☐

Was the recall appointment schedule followed ☐ Yes ☐ No

Description of event:

_____

_____

_____

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

Approximate number of uses: (Cutting instruments only) ☐ initial use ☐ 2–5 ☐ 6–10 ☐ 10–15 ☐ more than 15

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

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

Short description of incident:

_____

_____

Please return questionnaire, autoclaved product and include X-rays (as appropriate).
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 and label them as **sterile**.

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

Doctor's Signature: _____ Date: _____

FOR INTERNAL USE ONLY

☐ CSN ☐ PSO ☐ ASR ☐ RPC ☐ Info incomplete ☐ Std/No