Solidex Guarantee Questionnaire

1. CUSTOMER INFORMATION

Clinician's Name: _____ Customer Account #: _____

Address: _____ Telephone: _____

Reported by:_____

Lab Name: _____ Customer Account #: _____

Address: _____ Telephone: _____

Reported by:_____

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

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

_____

_____

_____

_____

3. GENERAL PATIENT INFORMATION (Only required with implant complaints)

Patient ID _____ Age _____ Female_____ Male _____

Medical Record:

___Diabetes Mellitus ___Psychological disorder ___Uncontrolled endocrine illness

___Radiation Tx-head/neck area ___Xerostomia ___Compromised immuno resistance

___Illness requiring steroids ___Lymphatic disorder ___Blood coagulation disorder

___Chemotherapy around time of implant placement ___Drug or alcohol abuse

Allergies: _____

Other Local or systemic diseases which may be significant: _____

Does the patient smoke? __Yes ___No ___No significant findings

4. SURGICAL INFORMATION (Only required with implant complaints)

___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 device from implant

___Removal of implant from vial Other:_____

Guarantee Questionnaire

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

Bone quality	___Type I	___Type II	___Type III	___Type IV
Was the site tapped?	___Yes	___No	___N/A	
Bone level profile drill used?	___Yes	___No	___N/A	
Tissue level profile drill used?	___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:_____

4. EVENT INFORMATION (Only required with implant complaints)

Hygiene around implant ___Excellent ___Good ___Fair ___Poor

Were any of the following involved in the event?

___Trauma/Accident	___Implant fracture	____Inadequate bone quality/quantity
___Biomechanical overload	___Overheating of bone	____Previous bone augmentation
___Immediate extraction site	___Peri-implantitis	____Nerve encroachment
___Adjacent to endodontic tooth	___Infection	____Sinus perforation
___Tongue (pressure)	___Bruxism	____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.

Guarantee Questionnaire

If the implant is not being removed, is there evidence of the following (check all that apply)?

Extent (mm): Bone Loss _____ Dehiscence _____ Peri-implantitis ____ Fenestration ____ Other _____

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

_____

_____

6. PROSTHESIS INFORMATION (Only required for abutment and restoration complaints)

Project no.:_____ ___Model ___Insertion ___In use

Type of restoration? ___Crown ___Bridge ___RPD (upper) ___RPD (lower)

___Full (upper) ___Full (lower) Other:_____

Date abutment was installed (D/M/Y) 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 (Only required for instrument complaints)

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 evidence to support issue (X-rays, designs of prosthetics, photos 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. Evaluation of claim is based on the Creodent Guarantee Terms and Conditions. Failure to return Solidex Items for evaluation as well a required evidence based on claim can result in denial of claim.**

Doctor's Signature: _____ Date: _____

Laboratory Signature: _____ Date: _____