

# Questionnaire for Complaint & Implant Failure



1. Customer Information		Restorative Doctor Information		
Account no.:				
Name:				
Address:				
Post/Zip code:				
Country:				
Tel. / E-mail:				
2. List of returned products				
Article no.	Product Description	Quantity	Tooth position	Lot No
3. Requested replacement components				
Article no.	Product Description	Quantity	Tooth position	Lot No
4. Patient Information				
Patient ID:	Age:	Female ( )	Male ( )	
1. Date of implant placement:		2. Date of implant exposure:		
3. Date of implant loading:		4. Date of implant removal:		
5. Your evaluation of the problem cause:		6. Describe problem:		
1. Unknown 2. Failure to osseointegrate - pre-loading (before exposure) 3. Loss of osseointegration - post-surgical loading of implant 4. Iatrogenic surgical trauma: 5. Diminished oral hygiene 6. Bone quality insufficient 7. Bone <i>quantity</i> insufficient 8. Biomechanical overload or stress 9. Broken component 10. Others				