

Report Form for Dental Implant failure

A. Reporter Information

Surgeon's name _____

Address _____

E-mail _____

Contact in your country _____

B. Device Description

Catalog number _____ Lot number _____

Tooth number _____

Quantity returned _____

Type of Implant _____ Length _____ Width _____

C. Patient Information

Patient Name or number _____ Sex : M F

Age at time of event _____ years

Bone type _____

Patient's health condition _____

Medications (please specify)

Head and Neck Radiotherapy: yes / no Chemotherapy: yes / no

Bisphosphonates taking: yes / no

Smoking: yes / no Diabetes: yes / no Bruxism: yes / no

Oral hygiene: poor moderate good excellent

D. Chronology of Events and surgical phase

Implant Placement Date _____ Removal Date _____

Implant placement after extraction: immediate 1-4 weeks 4-12 weeks 12-24 weeks
and more than 6 months

Pre-surgical medication: Mouth rinse: yes / no

Antibiotics: yes / no

Previous additional surgery: bone graft

Membrane

Sinus elevation

E. Event Description

Lack of integration: yes / no Lost integration: yes / no

Mechanical Malfunction: yes / no

Other: _____

Was implant restored? yes / no

If yes, was it immediate/early load? Yes/ no Less than 4 months: yes / no

Describe what happened to the patient as a result of this event:

Discomfort: yes / no

Edema: yes / no

Pain: yes / no

Infection: yes / no

Soreness: yes / no

Swelling: yes / no

Surgical intervention: yes / no

Wound dehiscence: yes / no

Bone loss: yes / no

Was the site grafted? Yes / no

Please send this report with the failed implant **(into sterilized envelope)**

To: Nof Bldg. Migdal TEFEN iNdustry Zone

P.O.Box 49, 24959 ISRAEL