WARRANTY QUESTIONNAIRE

Z-SYSTEMS swiss ceramic implants

Please complete this form with as much details as possible. If appropriate, attach the product(s) in sterile condition and any relevant radiographs or clinical photos to this form.

Z-SYSTEMS USE ONLY	
Complaint/ Feedback N°:	
Product returned and sterile?	○ yes ○ no
Complaint (C) or feedback (F)?	○ C ○ F
Reportable event?	○ yes ○ no
Information complete:	○ yes ○ no
Date:	**Signature:**

PLEASE NOTE:

- Product(s) must be returned within 30 days of the date of the event.
- Returned product must be autoclave sterile (to protect our employees) but not cleaned, packaged in protective pouch and labelled "sterile".
- Only signed and properly documented Warranty Questionnaires will be considered.
- Only one replacement implant per day and per tooth qualifies for replacement.

CUSTOMER INFORMATION

Clinician: _____ **Facility:** _____

Address: _____ **City:** _____

Phone: _____ **E-Mail:** _____

PATIENT INFORMATION *for privacy DO NOT use patient's name*

Patient ID: _____ ○ Smoker ○ Bruxism ○ Compromised immunity

Age: _____ ○ Drug or alcohol abuse ○ Xerostomia ○ No significant findings

Gender: ○ m ○ f ○ div. ○ Diabetes mellitus ○ Limited oral hygiene ○ Other: _____

PRODUCT INFORMATION

REF-Number	Lot Number	Placement Date / Event date	Regio
		/	
		/	

SURGERY INFORMATION

Time of implantation
○ immediate implantation
○ early implantation
○ late implantatation
○ no information

Bone quality
○ D1
○ D2
○ D3
○ D4

Bone defects
○ horizontal
○ vertical
○ no information

Insertion mode/torgue
○ manual/_____Ncm
○ mechanical/_____Ncm

Protection
○ long-term prov. restoration
○ prothesis
○ protective splint
○ other

Sinus elevation
○ yes ○ no

Augmentation
○ yes ○ no

Was primary stability achieved? ○ yes ○ no
Was osseointegration achieved? ○ yes ○ no

PROSTHESIS INFORMATION

Temporary restoration/Date: _____
○ long-term provisional
○ bridge
○ other _____

Final restoration/Date: _____
○ crown
○ bridge
○ other _____

EVENT INFORMATION

Were any of the following conditions involved in the event?
○ Trauma/Accident
○ Peri-implantitis
○ Sinus perforation
○ Infection
○ Implant fracture
○ Abutment fracture
○ Poor bone quality
○ Poor bone quantity
○ Chipping during insertion
○ Biomechanical overload
○ Bruxism
○ Bone augmentation

At the time of the event/implant removal:
○ Inflammation
○ Mobility
○ Asymptomatic
○ Swelling
○ Pain
○ Bleeding
○ Fistula
○ Increased sensitivity
○ Numbness
○ Hypersensitivity
○ Abscess
○ other: pls describe below

Please describe the event: Why do you think the event occurred?

Before sending the complaint (please tick the box when read):

○ *We hereby confirm that the product was used according to the instructions for use (IFU).*
○ *We hereby confirm that the warranty conditions are read and accepted.*
○ *Autoclave all products, but do NOT clean them, and mark them STERILE.*
○ ***Send the product and this completed form to your local distributor.***
○ ***Complete this template, including name, date and signature and send it including x-rays by e-mail to quality@zsystems.com.***

Name: _____

Date: _____ **Signature:** _____

CONTACTS

If you have any queries, please contact your Z-Systems Territory Manager or Support: ***support@zsystems.com*** *.*

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