

Implant Warranty Form

Practitioner Information:

Clinician Name: Account ID:
Address: Clinic Name:
Phone: Email:

Patient Information:

Patient ID: Sex: Male Female Age:

Medical History:

Bruxism: Tobacco Use: Alcoholism: Hypertension: Diabetics: Cardiac Disease: Cancer:
Others (Please Explain):

Oral Hygiene:

Good: Moderate: Poor:

Bone Condition:

Good: Moderate: Poor:

Surgery Information:

Implant Placement Date: Implant Removal Date:
Traditional 2 stage: 1 Stage: Initial Implant Failure: Healing Abutment Load:
Prosthetics attachment: Crown: Bridge: Denture:
Others (Please Explain):

Bone Augmentation Use: Yes: No:

Implant (Tooth) Location No.	Item Code No.	Lot No.	Serial No. (from Sticker on Box)

Please indicate the reason for implant removal:

Infection: Pain: Abnormal Sensation: Bone Condition: Implant Fracture: Sizing:
Poor Oral Hygiene: Patient Health Habit: Unexpected Surgical Trauma:
Others (Please Explain):

- Please include a copy of the product lot number sticker placed on the patient's chart.
- Return all sterilized products with this failure form for evaluation by Dentis USA Corp.
- Each product(s) must be returned in a sanitized bag within 15 working days of failure date.
- This form must be filled out completely to receive the replacement product(s).

Please indicate the outcome of the patient: _____

Signature: _____ Date: _____

Submit Form to order@dentisusa.com.

