Appendix B

Product Failure Report

Implant Failure Report	C/N		Aware Date	

Practitioner Information **Description of Product:** _____

Surgeon name: _____ Account No._____

Address: _____ Phone:_____

_____ Fax:_____

Reason for returning: _____

Patient Information

Patient ID (Chart No.): _____ Sex: _____ 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

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Surgery Information

Product Placement Date: _____ Product Removal Date: _____

Surgery: □ Traditional 2 stage □ 1 Stage □ Initial implant failure (did not complete implantation)

□ Fixture was placed with primary closure. □ Healing Abutment load

□ Prosthetics attachment (□ single □ bridge □ denture)

□ Other (please explain):_____

Bone augmentation material use: □ Yes □ No

Implant (Tooth) Location No.	Implant Model No.	Lot No.

Implant was removed because Of:

□ Infection □Pain □ Abnormal Sensation □ Bone condition □ Implant Fracture □ Sizing

□ Poor oral hygiene □ Patient health habit □ Unexpected surgical trauma

□ Others (please explain): _____ Patient Outcome: _____

Notices:

Product returns should be cleaned or disinfected prior to returning, for close evaluation by the manufacturer. Each product must be returned separately in a sanitized vinyl bag with a clear indication tag and this form attached.