Form – PM

Please fill in the form in order to follow up customer complaints.
NOTE: Please also read the Information Sheet "Causes of Implant Failure". Please transmit via email or fax to your Ritter Representative!

A. Information				
Dr. Name/ Practice (Clinic) Name:				
Address: City, State, Country				
B. Medical Device Identification				
Dental Implant *(Information as mentioned on the product label)*	REF #: LOT #:	Or insert Image of Label from Implant package Here:		
	Date of Implant placement:			
	Torque value:			
	ISQ value:			
	Recorded gingival height in mm:			
	Recorded measurement to proximal teeth:	a)	b)	
	☐ Drill #1	REF #:	LOT#:	Date:
	☐ Drill #2	REF #:	LOT#:	Date:
	☐ Drill #3	REF #:	LOT#:	Date:
	☐ Drill #4	REF #:	LOT#:	Date:
	☐ Drill #5	REF #:	LOT#:	Date:
	What was used to irrigate the site:	☐ Chlorhexidine ☐ Saline ☐ Water ☐ Other:		
	Other:			
Parts Used *(Information as mentioned on the product label)*	☐ Healing Cap	REF#:	LOT#:	Date of placement:
	☐ Temporary Abutment	REF#: Torque value:	LOT#:	Date of placement:
	☐ Final Abutment	REF#: Torque value:	LOT#:	Date of placement:
	☐ Custom Abutment- Who was the fabricator?	Torque value:		Date of placement:
C. Was Bone Augmentation Performed ? ☒ Yes ☐ No				
	Date of Bone Augmentation:			
	Type of Bone Augmentation:			
	Composition of Bone Graft:			
	Brand of Graft :	REF #	LOT #	
	Other :			

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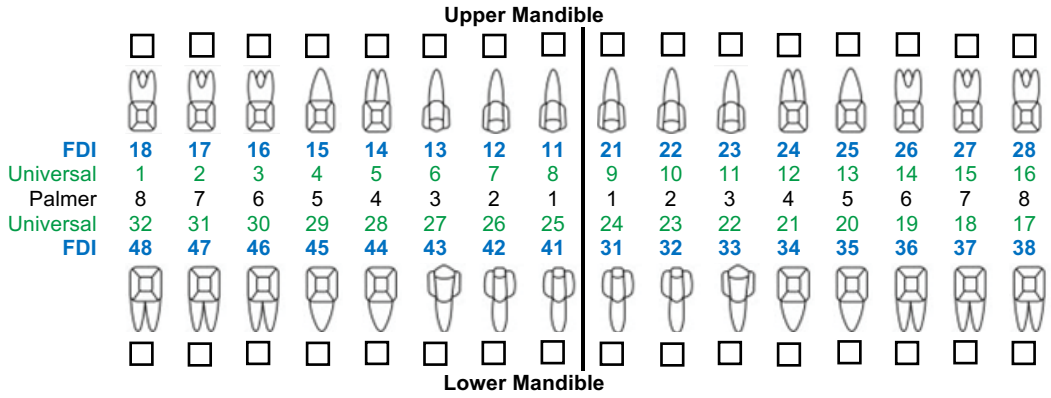
D. Tooth Extraction	☐ Yes ☐ No		
	Date of Extraction:		
	Reason of Extraction:		
	Infection Present at time of Extraction:		
	If yes, how was the infection eradicated:		
	X-Ray taken? ☐Yes ☐No	Dates of X-Rays:	
	Other:		
E. Patient Information			
Anonymized patient no.:			
Patient age:			
Tooth/s No./ Positions:			
Bone Density Type:	☐I	☐II	☐III	☐IV
	Was a CBCT used to determine Bone Density?		☐Yes	☐No
Other relevant history:	Smoker:		☐Yes	☐No
	Bruxing:		☐Yes	☐No
	Good Oral Hygiene:		☐Yes	☐No
	Pre-Existing medical condition. If yes, please describe below:		☐Yes	☐No
	Diabetes		☐Yes	☐No
		A1C Level	Pre-op:	Post-op:
	Periodontal Disease		☐Yes	☐No
	Osteoporosis:		☐Yes	☐No
	Vitamin D Level:	Pre-op:	Post-op:	
	Other:			
	Other:			
F. Chronology of Events				
Failure/Removal of Implant	Date* :	ISQ Value :	Bone Density in Hounsfield Units:	
	Other:			

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G. Event Description			
Structural Integrity of Implants or Parts	Implant	☐Yes	☐No
	Abutment	☐Yes	☐No
	Screw	☐Yes	☐No
	Other:	☐Yes	☐No
Description of Event: (Check one)	Lack of integration:	☐Yes	☐No
	Lost integration:	☐Yes	☐No
What happened to the patient as a result of this event? Please indicate by using Yes or No.	Pain	☐Yes	☐No
	Instability	☐Yes	☐No
	Bleeding, Wound Dehiscence	☐Yes	☐No
	Inflammation, Allergy	☐Yes	☐No
	Peri-implantitis	☐Yes	☐No
	Bone Loss	☐Yes	☐No
	Further comments:		
Please attach digital X-ray/PAN/3D picture	☐ Picture enclosed		

I hereby confirm that the above information is complete, true and correct.

Date [Date YYYY-MM-DD]: _____

*The date above must be within 30 days of the failure date to qualify for credit

Stamp and Signature: _____

Only to fill out by Ritter Representative:

Received form on (date): _____ Parts replacement: ☐ yes ☐ no

Submit form