

COMPLAINT FORM BEGO IMPLANT SYSTEMS

Case history	
General illnesses	_____
Current medication	_____
Neurological disorders	_____
Smoker	<input type="radio"/> Yes <input type="radio"/> No
Other	_____
Occlusion	Angle class <input type="radio"/> I <input type="radio"/> IIa <input type="radio"/> IIb <input type="radio"/> III
Occlusal interference	_____
Elongated teeth	_____
Intercuspitation	<input type="radio"/> Canine guidance <input type="radio"/> Occlusion
Cusp inclination	<input type="radio"/> Steep <input type="radio"/> Moderate <input type="radio"/> Flat <input type="radio"/> None
Parafunctions	<input type="radio"/> Bruxism <input type="radio"/> Tongue thrust

Suspected cause of failure (implant failure/complications)	
<input type="radio"/> Insufficient available bone	
<input type="radio"/> Trauma during placement	
<input type="radio"/> Poor primary stability	<input type="radio"/> Buccal bone lamellae fractured
<input type="radio"/> Extremely hard bone	<input type="radio"/> Simultaneous augmentation and implantation
<input type="radio"/> Healing phase too short	
<input type="radio"/> Infection	
<input type="radio"/> During the healing phase	<input type="radio"/> After the prosthetic treatment
<input type="radio"/> Occlusal trauma	
<input type="radio"/> Other trauma	
<input type="radio"/> Other cause	_____

Description of the complication (with treatment data)

(Place, date, signature, stamp)	To be completed by BEGO Implant Systems. Complaint no.: _____ Date received: _____ Processed by: _____
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To process a complaint properly all of the items listed below must be submitted together with this form.

- Product forming subject of complaint
- Goods return form
- All x-rays from this case*
- Complete documentation*
- Prosthetic constructions (e.g. bridge or bar)
- Planning and working models if applicable
- Photo if applicable

Goods returned as part of a complaint are only accepted if they are sent to BEGO Implant Systems GmbH & Co. KG accompanied by the corresponding goods return form.

*Without stating the patient's name

Surgeon/implantologist:

Name _____

Address _____

Tel./ Fax _____

Prosthodontist:

Name _____

Address _____

Tel./ Fax _____

Patient:

Patient identification/year of birth _____



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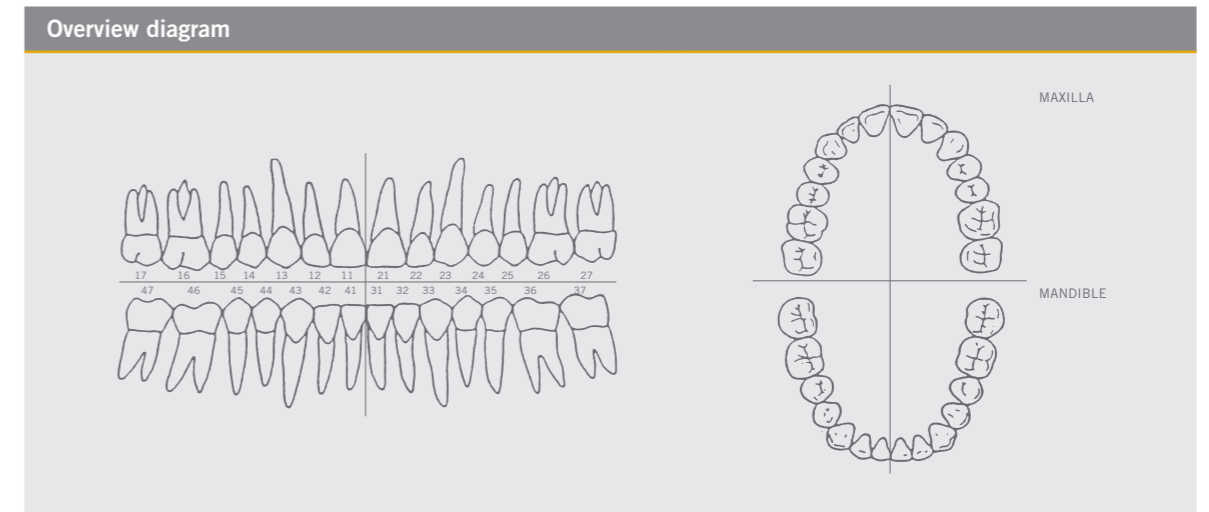
Treatment data	
Extraction of the replaced tooth (weeks before implantation/augmentation)	_____
Implant position/augmentation region _____	Date of implantation _____
Width of the crestal alveolar process at the implantation site _____	(mm)
Bone quality	<input type="radio"/> D1 <input type="radio"/> D2 <input type="radio"/> D3 <input type="radio"/> D4
Speed used	_____ (U/mm)
Pretapped thread	<input type="radio"/> Yes <input type="radio"/> No
Countersink used	<input type="radio"/> Yes <input type="radio"/> No
Torque used during insertion	_____ (Ncm)
Tool used	<input type="radio"/> Ratchet <input type="radio"/> Handpiece <input type="radio"/> Handwheel
No tool, rather	_____
Simultaneous osteoplasty with	Materials used
<input type="radio"/> Chips and membrane	_____
<input type="radio"/> Titanium mesh/film	_____
<input type="radio"/> Lateral onlay (pressure screw)*	_____
<input type="radio"/> Vertical onlay (pressure screw)*	_____
<input type="radio"/> Sinus floor elevation	_____
<input type="radio"/> autologous bone*	_____
<input type="radio"/> artificial bone	_____
<input type="radio"/> mixture*	_____
*Harvest site	_____
Augmentation with	_____
<input type="radio"/> Granules	_____
<input type="radio"/> Granules + membrane	_____
<input type="radio"/> Block	_____

Healing phase				
Healing	<input type="radio"/> Covered	<input type="radio"/> Insecurely covered	<input type="radio"/> Open	
Loading	<input type="radio"/> Not loaded	<input type="radio"/> Immediately loaded (with temporary restoration)	<input type="radio"/> Immediately loaded (with final restoration)	<input type="radio"/> Delayed loaded (after osseo-integration)
Healing period not loaded				_____ days
Period between exposure and insertion of final prosthesis				_____ days

Recall phase	
Recall interval/dates	_____
Level of hygiene (1 = excellent to 6 = inadequate)	_____

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Implant-borne prosthesis	
Single crown(s) on implant	_____
Crown block	_____
Bridge from _____ over _____ to _____	
Bar with removable prosthesis on _____	as abutments
Bar with limited prosthesis removal on _____	as abutments
Extension bar(s) region	_____
Ball attachment anchor on implant	_____
Locator®/Easy-Con abutment	_____
Telescopic crowns	
<input type="radio"/> Parallel-walled	Cone angle <input type="radio"/> 6° <input type="radio"/> 8° <input type="radio"/> 10° <input type="radio"/> >10°
Torque used during fixation	_____ (Ncm)
Other	_____



Product forming subject of complaint (implants / prosthetic components/biomaterial)					
Position					
Article					
Article no.					
Batch no.					