GUARANTEE QUESTIONNAIRE

Z-SYSTEMS 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 to this form.

Z-SYSTEMS USE ONLY	
Complaint N°:	
Product returned and sterile?	O yes O no
Expiration date of product:	
Information complete:	O yes O no
Evaluation by CCA?	O yes O no
Evaluation by Product Specialist?	O yes O no
Date: **Signature:**	

REPLACEMENT CONDITIONS

- Product(s) must be returned within 90 days of the date of the event.
- Product must be shipped sterile and in a protective pouch.
- Only one replacement implant per day and per tooth qualifies for replacement.
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CUSTOMER INFORMATION

Clinician: _____ **Facility:** _____

Address: _____ **City:** _____

Phone: _____ **E-mail:** _____

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

Patient ID: _____ ☐ Smoker ☐ Bruxism ☐ Limited oral hygiene

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

Gender: m ◯ f ◯ ☐ Diabetes mellitus ☐ Compromised immunity ☐ Other: _____

PRODUCT INFORMATION

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

SURGERY INFORMATION

Time of implantation
◯ immediate
◯ delayed immediate
◯ late implantation
◯ n/a

Bone quality
◯ D1
◯ D2
◯ D3
◯ D4

Bone defects
◯ horizontal
◯ vertical
◯ n/a

Insertion mode/torque
☐ manual _____Ncm
☐ mechanical/_____ Ncm

Protection:
◯ long-term prov. restoration
◯ prothesis
◯ prothesis
◯ 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
☐ Fistula
☐ Swelling
☐ Pain
☐ Bleeding
☐ Asyptomatic
☐ Increased sensitivity
☐ Numbness
☐ Hypersensivity
☐ Abscess
☐ other: *pls describe below*

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

Before sending the complaint:

○ *Verify the terms and conditions.*
○ *Sterilize the product and mark it STERILE.*
○ *Attach the product and the x-rays to the questionnaire.*

Name: _____

Date: _____ **Signature:** _____

GUARANTEE QUESTIONNAIRE

YOUR OPINION IS IMPORTANT TO US

	1-10 (1=poor, 10=very good)
Are you informed about new product developments fully and in sufficient time?	
How do you evaluate the completeness & user-friendliness of the product documentation?	
How do you evaluate the usefulness and user-friendliness of the training material?	
How do you evaluate the product training provided by Z-Systems AG overall?	
How satisfied are you with the advice and support given in problem situations?	
How does the delivery service operate?	
How satisfied are you with how your feedback and needs are taken into consideration?	

Comments

CONTACTS

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

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THE GUARANTEE CASES ARE TO BE SENT TO YOUR LOCAL Z-SYSTEMS LEGAL ENTITY (SEE ABOVE)!