S. I. N.
Implant System

Product evaluation form
Implant

Dear Dentist,

Any occurrence relating to our products is extremely important to us. In that way, we ask you to complete and submit information to our analysis are carried out completely. This information is critical to a detailed analysis of the event.

Assumption:

- Must be filled out a form for each product claimed.
- The products should be sent to S.I.N. sanitized and sterilized in suitable packaging to autoclaving, closed and with evidence of sterility through ribbon specifies.
- It must be sent to the SIN set containing the product, the completed form also periapical or panoramic radiographs.

If one the above is not met the product will be returned to the client.

Customer Information

Name/Corporate name:

*IDNumber: *Phone: *Cel Phone:

E-mail:

Address: Nº:

Complement: District: Zip Code:

City: UF: Country:

Product Information

*Code: *Description:

*Nº Lot: Quantity: Bill of sale:

Patient Information

Name/ID:

*Age: *Gender: Female Male

*Clinical history: Mellitus Diabets Hypertension Xerostomia Bruxism Smoking

Allergy or hypersensitivity Immunologic deficiency Chemotherapy Another disease (mention which):

Oral hygiene: Good Regular Bad

If you make use of any medication (mention which).

Surgery Information

Date: Reason for return:

Packaging Osseointegration No Inability Installation Fracture

Other (describe):

Brief description of occurrence:

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Surgery Information

Fill in all the fields in case of no osseointegration.

*Date of implant removal:

Bone type: I II III IV *Immediate loading? Yes No

*Used tools and cutters of S.I.N.? Yes No

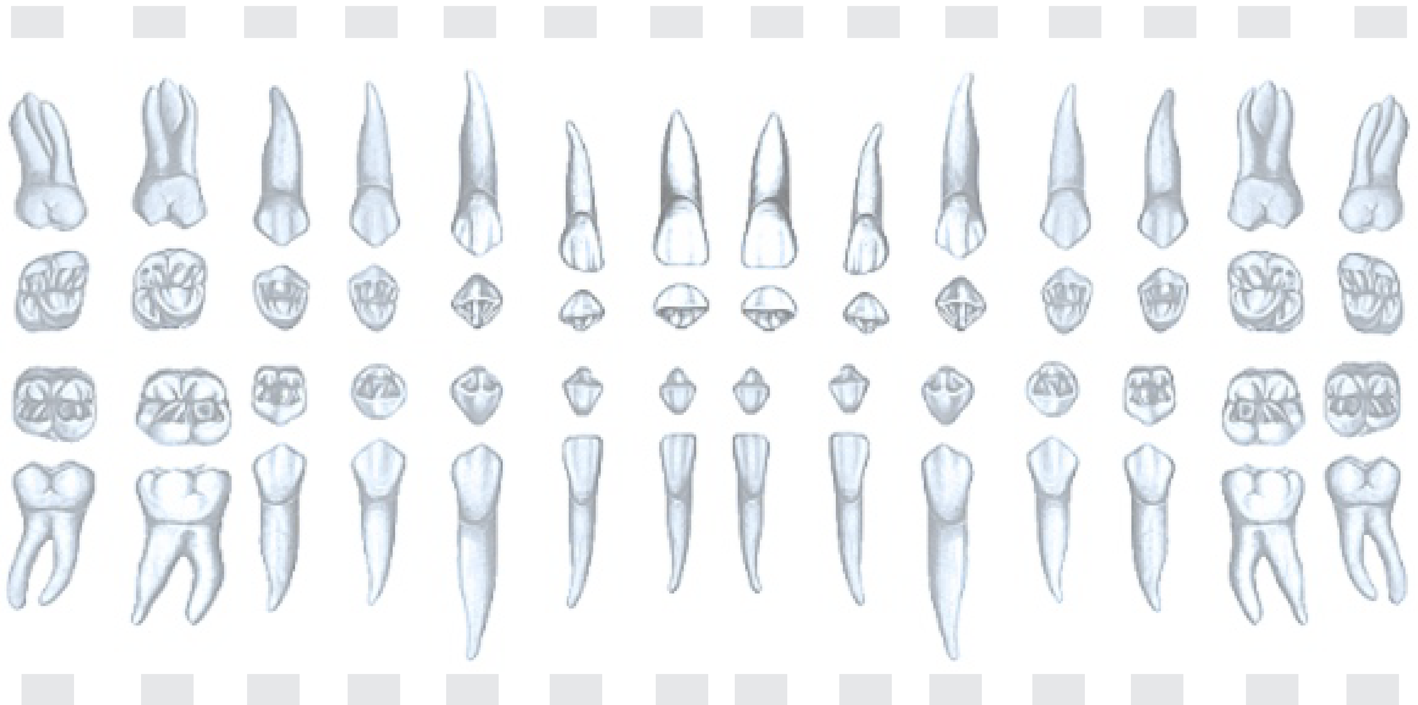
*Describe sequence used cutters:

It was used expander/compressor? Yes No

If so, what diameters of the last expander/compressor

Bone graft was done on site? Yes No

I so, what material was used?



*Declaration of Truthfulness

I , declare to be true the information provided provided herein. I also declare that the products shipped are properly sterilized.

Date:

Signature: