Complaint form 1|4

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This Complaint form refers to the Terms and Conditions of the Patent™ Lifetime Guarantee (MKT 400) of Zircon Medical Management AG.

1 Customer information

Company stamp

C | | | | | |
Customer number

Company

Contact / Name

Telephone

Email Address

Address

City

Date / Signature

2 Date of event

Date of event DD/MM/YYYY

The Zircon Medical Management AG guarantee is not valid for complaints where the referred date of event has occurred more than three months before the date of complaint.

3 Product(s) concerned (claimed to be replaced)

Article No.	Description	Lot No.	Qty.	Reason for return [1]

Restoration type? Crown, bridge...

[1] Use Chapter 7 in case of more detailed information

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4 Patient information

Patient ID / Ref

Age ☐ m ☐ f

Country of residence

5 Patient Medical History

Any known disease? ☐ No ☐ Yes (specify)

Any special treatment (chemotherapy, radiotherapy...)? ☐ No ☐ Yes (specify)

Any special medication? ☐ No ☐ Yes (specify)

Any parafunction behavior (bruxism...)? ☐ No ☐ Yes (specify)

Any infection? ☐ Nein ☐ Yes (specify)

Bone density ☐ Type I ☐ Type II ☐ Type III ☐ Type IV

Bone quantity ☐ Poor ☐ Moderate ☐ Good

Oral hygiene ☐ Poor ☐ Moderate ☐ Good

Smoker ☐ No ☐ Ja

6 Treatment information

Were the appropriate Instructions for Use (IFU) and user guide, valid at the time of treatment, strictly followed ☐ No ☐ Yes

Was/Were the Patent™ Implant and/or the Patent™ Prosthetic Component used in combination with other manufacturer's products ☐ No ☐ Yes (specify)

Implantation date DD/MM/YYYY

Tooth No.

Type of insertion protocol ☐ Manual ☐ Motor

Cortical Drill used? ☐ No ☐ Yes

Tap used? ☐ No ☐ Yes

Immediate placement ☐ No ☐ Yes

Immediate loading ☐ No ☐ Yes

Primary stability ☐ Poor ☐ Moderate ☐ Good

Secondary stability (osseointegration) ☐ Poor ☐ Moderate ☐ Good

Any pre-treatment medication (antibiotics...)**?** ☐ No ☐ Yes (specify)

Any additional surgery? ☐ No ☐ Yes (specify)

7 Further information related to the event / complaint

Please note that the product(s) of concern is/are an essential part of the complaint assessment and need to be handed over to Zircon Medical Management AG for evaluation. Returned products are only accepted when sterilized accordingly and packed in pouches with clear colour change of the sterilization indicator. Alternatively to this indicator, sterilization protocols or records are also accepted.

☐ I confirm that the product(s) is/are sterilized and packed in pouches.
A clear colour change of the sterilization indicator or a sterilization protocol / record is available.

Date

Signature

Immediately after completing this Complaint form the following tasks must be carried out:

- The digital version of this form must be sent to **info@zircon-medical.com**
- The sterilized product(s) of concern listed under Chapter 3 must be sent together with the physicaloriginal version to the following address:
  Zircon Medical Management AG, Churerstrasse 66, 8852 Altendorf, Schweiz

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To be filled out only by the Quality Management Department of Zircon Medical Management AG:

Date of receipt of the signed Complaint form DD/MM/YYYY

Product(s) of concern in required conditions received? ☐ No ☐ Yes

Date

Signature and company stamp (Please block letters only)

Unterschrift und Firmenstempel

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