

Please fill in and attach the return item.

Ship it to **B&B DENTAL AUSTRALIA** Unit 1, 233-235 Greenhill Rd. DULWICH SA 5065

TYPE OF IMPLANT

Ref CODE

LOT NUMBER

NUMBER OF IMPLANTS INSERTED

NUMBER OF IMPLANTS RETURNED

NUMBER OF FAILED IMPLANTS

IMPLANT INSERTION DATE

IMPLANT REMOVAL DATE

X-RAY PROVIDED

Yes

No

PATIENT DATAS

MOTIVATE THE LOSS OF OSTEOINTEGRATION AND DESCRIBE THE CLINICAL COURSE

NAME

AGE

GENDER

Female

Male

HYGIENIC CONDITIONS

GENERAL HEALTH

SMOKER

Yes

No

Does the patient have diabetes?

Yes

No

Is the patient taking drugs for osteoporosis?

Yes

No

*If yes list the medication/s

Was the area inflamated at the time of placement?

Yes

No

List of drugs that the patient was taking in the period of the surgery?

DENTIST DATAS

CLINIC NAME

Dr NAME

Have you already used this type of implants before?

Yes

No