Warranty & Guarantee request

To be completed by MegaGen:
Fileref.: _____ Signature: _____

Please sterilise the product before shipping. Non- sterilised products will not be processed as they may pose hazards to MegaGen employees. Each product must be returned separately in a sanitized bag with a cleaner indication tag and this form attached.

Reason of returning: ☐ No osseo integration ☐ Peri-implantitis ☐ Sizing ☐ Fracture

Practitioner information:

Surgeon Name: _____ Practice name: _____

Address: _____

Phone: _____ E-mail: _____

Patient Information:

Patient number*: _____ Sex: ☐ Male ☐ Female ☐ X Age: _____

*For privacy **Do Not** use patient's name:

Medical History:

☐ Diabetes Melitus ☐ Radiation Tx (head/ neck area) ☐ Drug or alcohol abuse

☐ Xerostomia ☐ Coincident chemotherapy ☐ Tobacco use

☐ Relevant allergies ☐ Relevant diseases ☐ No significant findings

Product Information:

Please list the involved MegaGen product. *1 implant per form only

Implant Type	Implant Reference	LOT + SN no.	Placement Date	Removal Date	Location no.

Surgical Information:

☐ Handpiece & Manual placement ☐ Handpiece placement ☐ Manual placement

☐ Final drill before implant placement: _____

☐ Approximate number of uses of the final drill: ☐ Initial use ☐ 2-9 ☐ 10-19 ☐ 19-25 ☐ More than 25

☐ Torque end value on insertion: _____ Ncm

Bone condition	☐ D1	☐ D2	☐ D3	☐ D4
Oral hygiene	☐ Good	☐ Moderate	☐ Poor	
Surgery type	☐ Immediate	☐ 1-stage	☐ 2-stage	
Was primary stability achieved?	☐ Yes	☐ No		
Has the implant been osseointegrated?	☐ Yes	☐ No		
Were other implants placed during treatment?	☐ Yes	☐ No		
Bone augmentation used during treatment?	☐ Yes	☐ No	☐ N/A*	

*Not applicable

MEGAGEN BENELUX

Company address
MegaGen Benelux BV
Schijfstraat 24
5061 KB Oisterwijk
Netherlands

Postal address
MegaGen Benelux BV
Postbus 649
5000 AP Tilburg
Netherlands

Contact
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info@megagen.nl
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info@megagen.be

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www.megagen.be

Warranty & Guarantee request

MEGAGEN BENELUX

Mandatory x-ray:

In order for the application to be considered and properly assessed, the following X-rays are required to be supplied.
Please tick box and enter relevant file name on the line provided.

	☐ No osseointegration	☐ Peri-implantitis	☐ Fracture
Initial Situation (before implantation)	☐ _____	☐ _____	☐ _____
Initial Situation (after implantation)	☐ _____	☐ _____	☐ _____
Impression (analogue/ digital)		☐ _____	☐ _____
Prosthetic Provision (after loading in-situ)		☐ _____	☐ _____
Before Explantation		☐ _____	☐ _____

Abutment Information:

Please list the involved MegaGen product. *1 abutment per form only

Abutment Type	Abutment Reference	LOT no.	Placement Date	Removal Date	Location no.

Prosthesis Information:

Only applicable if the prosthetic restoration has been placed.
The original MegaGen abutment should be entered under 'Product Information' on page 1.

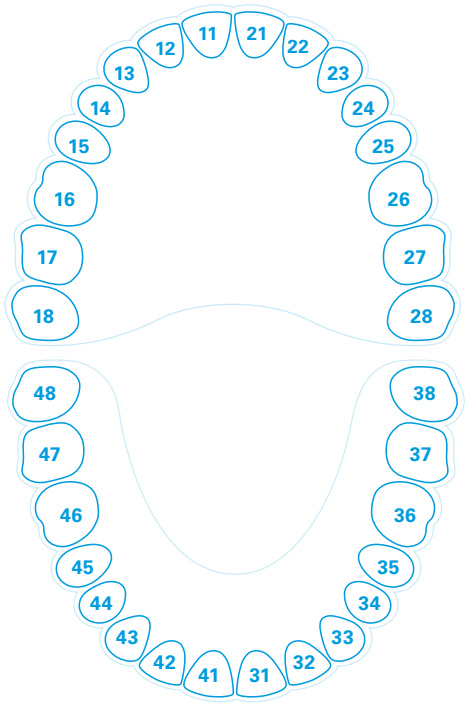
Name and address of dental laboratory/dental prosthetic practice: _____

Type of restoration?
☐ Full Bridge (lower) ☐ Bridge ☐ RPD* (lower) ☐ RPD* (upper)
☐ Full Bridge (upper) ☐ Crown ☐ Other: _____

Date abutment was installed _____

Date abutment was removed _____

Torque value applied on installing _____ Ncm



Description of event:

Date _____ Signature _____

By submitting this form you agree to our terms and conditions.

* Removable partial denture

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