Customer Feedback Form

The inclusion of as many details as possible greatly aids the complaint investigation process as well as provides useful information for continuous improvement. **Missing information will delay processing.** ***All fields are required.***

A. Customer Information

Date of Report: _____
Account # _____
Account Name/Dr: _____
Address: _____
City, State, Zip, Country: _____
Phone #: _____
E-mail: _____
Submitted By: _____

B. Product Information: One form should be used per patient or event. If more than one device is associated with a single reported event, multiple item numbers may be included below.

Component Type:
☐ Implant ☐ Abutment ☐ Screw ☐ Instrument/Tool ☐ Other _____
Order # (if available): _____

Item Number	*Lot/Serial #*	*Qty.*

C. Product Replacement

Are we replacing the same product? ☐ Yes ☐ No - please provide preferred length and diameter _____
(if not specified, same size implant will be sent as a replacement). Store Credit will not be issued in lieu of replacement.

Patient/Case ID: _____

D. Event Information

Implantation Date (mm/dd/yy): _____ ***Loading Date*** (mm/dd/yy): _____ ***Removal Date*** (mm/dd/yy): _____

Description of the Event (check all that apply):
☐ No Primary Stability ☐ Failure to integrate (Before or coincident with loading) ☐ Loss of Integration (After Loading)
☐ Packaging or Labeling ☐ Fit ☐ Fracture ☐ Customer Service ☐ Other (please describe): _____

Discovered During:
☐ Receiving ☐ Unpacking ☐ Clinical Procedure ☐ Laboratory Procedure
☐ Other: _____

Procedure Completed in the Same Visit:
☐ Yes ☐ No

Provide a detailed description of the reported problem (including procedure being performed, related products and settings used): _____

Outcomes Attributed to Event:
☐ Death
☐ Life Threatening
☐ Hospitalization
☐ N/A
☐ Required Intervention to Prevent Permanent Impairment
☐ Disability or Permanent Damage
☐ Other Serious (Important Medical Events)

Describe Any Signs or Symptoms present in patient as a result of the event (check all that apply):

☐ No Patient Impact ☐ Allergic Reaction ☐ Aspiration ☐ Hemorrhage ☐ Nerve Damage ☐ Pain ☐ Bone Loss
☐ Dehiscence ☐ Delayed Healing ☐ Edema ☐ Hyperesthesia ☐ Hyperplasia ☐ Infection ☐ Inflammation
☐ Other: _____

E. Patient Information

Gender: ☐ Male ☐ Female

Age at Time of Event: _____

Tooth Number: _____

Bone Density Type: ☐ I ☐ II ☐ III ☐ IV ☐ Unknown

Oral Hygene: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Other Relevant Patient History (check all that apply):

☐ Smoker/Tobacco use ☐ Bruxism /Clenching ☐ Osteoporosis ☐ Diabetes ☐ Biphosphonate Therapy ☐ Steroid Therapy
☐ Chemotherapy ☐ Radiation Therapy ☐ Periodontitis ☐ Other: _____

Instructions for US/Canada Customers and International Distributors:

1. Please complete each field of this form.
2. Submit form to: info@i3implant.com
3. Within 14 business days of submitting this form, Customer Claims department will issue an RMA and a Fedex label for the return of the product.
4. Some complaint cases requiring additional evaluation may delay replacement orders.

5. Please email the pre-op xray and post-op xray of the implant placement. Please also email an xray of the failing implant and post-op xray after removal of implant including dates and patient ID number labeled correctly. Any other relevant info should be sent as well so we can ensure quick handling of your warranty request. Thank-you!

_____

When returning product the following guidelines must be followed:

- Used product MUST be sterilized in pouches which show sterility with color change or other indications prior to shipping.
- Please write claim number on the outside of the box. Must include a copy of the Return Material Authorization.

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