

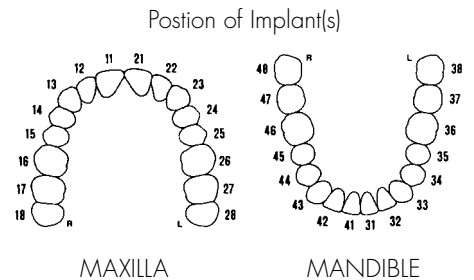
CAD/CAM Guarantee Form

CUSTOMER INFORMATION

Clinician's Name	<input type="text"/>	Customer Account #	<input type="text"/>
	<input type="text"/>	Order Number	<input type="text"/>
Address	<input type="text"/>	Telephone	<input type="text"/>
	<input type="text"/>	Country	<input type="text"/>
	<input type="text"/>	Reported by	<input type="text"/>

PRODUCT INFORMATION (Please list all involved Straumann Products)

Article Number	LOT Number	Placement Date (D/M/Y)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>



GENERAL PATIENT INFORMATION

Patient ID D.O.B. Female Male
 (D/M/Y) Weight kg

Oral Hygiene Excellent Good Fair Poor

PROSTHESIS INFORMATION

Type of prosthesis: _____

Date Abutment was installed

Torque control device used? Yes No Unknown N/A Torque applied Ncm

Date of temporary prosthesis installation Date of final prosthesis installation

Was the recall appointment schedule followed Yes No

Date of abutment removal (D/M/Y)

Comments:

Please include X-rays (as appropriate)
 Please use a padded pouch to return items – failure to do so could result in items lost during shipment
 Please **autoclave** all appropriate products and label them as sterile

Based on the Straumann CAD/CAM Guarantee Terms and Conditions P_RD_50141,
 please consider replacing the above listed products.

Customer's Signature: _____ Date: _____