

Neoss NCR-number	
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Section#01

Complete all section 1 and as appropriate section 2, 3, 4 or 5.
Send one form per patient.

Clinic/Customer Details			
Name		Account Number	
Address (Street, City, Country)		Tel	
		Contact Name	
Clinician Name		Email contact	

Product Information (Complete one line per item)				
Article Number	Lot Number	Quantity	Initial use date/ Placement date (DD/MM/YYYY)	Date of problem communicated to dentist/Removal date (DD/MM/YYYY)

Patient Information						
Oral Hygiene	Excellent		Good		Average	Poor
Smoker	Yes	No	Relevant medical history	Yes	No	
If yes provide further details below:						

Add description of failure, safety concerns (if any) and any additional information that may be relevant:		
Fracture	Yes	No

Section#02

If related to an implant, complete section 2 and then section 3 (if applicable).

Was implant restored with Neoss original or ARC prosthetics?						Yes	No				
When did the problem occur?	During surgery	During healing		At exposure		During loading	After restoration				
Position of implant failure	Bone Quality	1	2	3	4	Bone Quantity	A	B	C	D	E
Position of implant failure (if more than one failure)		1	2	3	4		A	B	C	D	E
Position of implant failure (if more than one failure)		1	2	3	4		A	B	C	D	E
		1=Dense		4= Soft		A= Most		E=Least			
Was primary stability achieved		Yes				No					

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Section#03

If related to prosthesis, complete the below section.

Type	Single crown	Partial bridge	Full arch bridge	Overdenture
	Temporary		Permanent	
How was it retained	Screw retained		Cement retained	Unknown
Ratchet used	Yes		Torque (Ncm)	No

Section#04

If related to an instrument, complete the below section.

Number of uses	0-1	2-10	10+
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Section#05

If related to a membrane, complete the below section.

How was it retained	Screws	Tacks
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Section#06

Please return pages 1 and 2 of the completed form and product, to the local office address listed on: www.neoss.com/support

NOTE#01: Please sterilize ALL items in a sealed pouch/packet which when returned will show proof of sterility. If sterilizing an implant, remove from glass ampule/container prior to sterilization! Do not return any implant in the glass ampule/container.

NOTE#02: Please use a padded pouch to return items to avoid damage.

Signature	Date (DD/MM/YYYY)

Neoss Internal Use Only

Identified Adverse event	Yes	No
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Warranty Request		Customer Complaint	
Within Neoss Warranty program?	Yes	No	Warranty program assessment performed within complaint handling process.
Signature		Date (DD/MM/YYYY)	