



# IMPLANT FAILURE QUESTIONNAIRE

<b>Reserved for Global D &amp; Partners:</b> Received by: Registration number (if applicable): Date: <hr/> Case number:
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## 1. PRACTITIONER INFORMATION

Customer Code (See delivery note and/or invoice): .....

Practitioner's name: .....

Email: .....

<b>Required attachments</b> 1. Products <b>MUST BE DECONTAMINATED, CLEANED, AND STERILIZED</b> 2. X-rays before and after implant placement and removal (if applicable post loading X-rays)
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## 2. PATIENT INFORMATION

Patient initials (3letters last name / 3letters first name): ..... Gender:  M  F Age: .....

### Bone density at implant site



**Type D1**  
Mainly compact bone



**Type D2**  
Thick cortical bone, low spongy bone volume



**Type D3**  
Thin cortical bone, dense spongy bone



**Type D4**  
Thin cortical bone, more abundant spongy bone

Lekholm and Zarb Classification (1985)

**Patient history:** Please provide all relevant information for case analysis (e.g., bruxism or hyperfunction, smoking, diabetes, alcohol consumption, tongue thrust, stuttering, allergies, infections...)

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## 3. SURGERY & PROSTHESIS

Last drill diameter:..... mm Implant torque: .....N.cm Final tightening with torque wrench  Yes  No

Bone graft performed, specify: .....

<b>Type of implantation</b> <input type="checkbox"/> Immediate post-extraction <input type="checkbox"/> Delayed	<b>Surgical procedure</b> <input type="checkbox"/> One-stage <input type="checkbox"/> Two-stage <input type="checkbox"/> Immediate loading	<b>Edentulism</b> <input type="checkbox"/> Single <input type="checkbox"/> Multiple <input type="checkbox"/> Full arch	<b>Prosthesis</b> <input type="checkbox"/> Cement-retained <input type="checkbox"/> Screw-retained <input type="checkbox"/> Removable
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## 4. PRODUCT INFORMATION

Tooth number	Implant		Dates		Prosthetic component or healing abutment		
	Reference	Batch Number	Placement	Removal	Reference	Batch Number	Date of placement

**Other implant sites**  Yes, specify site numbers: .....

## 5. REGARDING THE FAILURE (please tick only one of the four options)

<input type="checkbox"/> <b>Implant detachment</b> (from implant holder or other) Comments: .....	<input type="checkbox"/> <b>Lack of primary stability</b> (at implant placement) Comments: .....
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<input type="checkbox"/> <b>Early/Primary failure</b> (No osseointegration – Before loading) (Causes: e.g., bur wear, overheating, excessive compression, reuse of healing screw...) ..... ..... .....	<input type="checkbox"/> <b>Late/Secondary failure</b> (Loss of osseointegration) (Causes: e.g., early loading, biomechanical overload, bone loss, residual cement, prosthetic misfit, plaque, peri-implantitis...) ..... ..... .....
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## 6. DESCRIPTION

Please describe any notable events that could explain the implant failure(s): intraoperative complications, specific clinical conditions, patient risk factors, or any health deterioration that may have contributed.

Also indicate the consequences for the patient and/or practitioner: implant removal, additional surgery, treatment plan modification, discomfort, pain, etc.

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**⚠ If the email does not open automatically, please save the form and send it by email**