etk
A LYRA COMPANY

Folder number :

PATIENT FILE

Last name:

First name:

Birth date: |_|_| |_|_| |_|_|_|_|

Address:

Phone:

E-mail:

Numéro de sécurité sociale :

Mutuelle :

Practitioner responsible for follow-up:

Professional card number:

Allergies:

PATIENT FILE

NOTES

PATIENT RELATION

Informed consent
Prescription copy
Quotation

Mail for referent

PRE-IMPLANTATION INVESTIGATION

PRE-IMPLANTATION MEDICAL SURVEY

Last name

First name

Your height Your weight

Your family doctor

Date of your last visit to a dentist / /

Date of your last visit to a doctor / /

Date of your last blood tests / /

Do you currently take any drugs or medications? ●yes ●no

If yes, what are they, and for which treatments. (List all of them, do not omit any.) ●yes ●no

Have you ever had surgery? ●yes ●no

If yes, what were they and when?

Do you have heart disease? ●yes ●no

If yes, what kind?

Are you at risk of atherosclerosis? ●yes ●no

If yes, do you take anticoagulants? ●yes ●no

Does your blood have difficulty coagulating? ●yes ●no

Do you have any blood diseases? ●yes ●no

Do you have high blood pressure?

If yes, has it been balanced by your treatment? ●yes ●no

Do you have a serious or graft-related immune deficiency? ●yes ●no

Have you ever had a blood transfusion? ●yes ●no

Are you diabetic? ●yes ●no

If yes, are you diabetes insulin dependent? ●yes ●no

Is your diabetes balanced by the treatment? ●yes ●no

If yes, which treatment?

What is your usual blood sugar level?

Do you have vitamin-D deficiency? ●yes ●no

Do you suffer from severe hormonal? ●yes ●no

Have you ever had any of the following diseases or disorders?

Jaundice	●yes ●no	Hepatitis	●yes ●no	Depression	●yes ●no
Tuberculosis	●yes ●no	Glaucoma	●yes ●no	Coma	●yes ●no
Duodenal / ulcers	●yes ●no	Prostate problems	●yes ●no	Acute rheumatoid arthritisu	●yes ●no
Diabetes	●yes ●no	Eczema	●yes ●no	Anaemia	●yes ●no
Asthma	●yes ●no	Epilepsy	●yes ●no	Polio	●yes ●no

Have you ever had radiotherapy or chemotherapy? ●yes ●no

Have you ever had cervicofacial radiotherapy? ●yes ●no

Are you HIV-positive or have AIDS? ●yes ●no

If yes, what is the rate of your viral dose?

PRE-IMPLANTATION INVESTIGATION

PRE-IMPLANTATION MEDICAL SURVEY (follow)

Do you suffer from osteoporosis? ●yes ●no

If yes, what drugs or medications did you take?

Do you have an orthopedic prosthesis? ●yes ●no

Do you have any allergies or side effects to these products?

Antibiotics ●yes ●no Latex ●yes ●no Aspirin ●yes ●no

Analgesics ●yes ●no Lodine ●yes ●no Anesthetics ●yes ●no

Anti-inflammatory ●yes ●no Others, which ones?

Have you ever had to take bisphosphonates? ●yes ●no

If yes, for which etiology, what period, by which route of administration?

Do you smoke? ●yes ●no

If yes, how many cigarettes a day?

Do you regularly drink alcohol? ●yes ●no

If yes, how many times a week?

Do you regularly take any habit-forming substances other than alcohol or tobacco? ●yes ●no

If yes, which ones?

Do you have anything to add about your general state of health? ●yes ●no

If yes, which one?

Have you ever had complications following surgery? ●yes ●no

If yes, which ones?

Have you ever had complications during or after dental treatment? ●yes ●no

If yes, which ones?

Are you anxious-phobic about dental care? ●yes ●no

Additional survey for women patients

Are you, or do you think you may be, pregnant right now? ●yes ●no

If yes, which month of pregnancy are you right now?

Do you take a contraceptive? ●yes ●no

Are you menopausal? ●yes ●no

Do you take hormone substitutes? ●yes ●no

I, the undersigned , declare that I have answered this questionnaire honestly and with the intention of providing all the information required to allow me to receive the most appropriate treatment. In the event of any changes in my state of health or if new facts affecting it come to my attention, I will without delay inform the person who asked me to complete this questionnaire

Signed at

Signature preceded by the words “read and approved”

PRE-IMPLANTATION INVESTIGATION

PATIENT MOTIVATION:

- Pre-insight ■
- Treatment understanding ■
- Psychologically ready ■

TOOTHLESS ETIOLOGY:

- Tooth decay ■
- Trauma ■
- Parondontal disease ■
- Endodontic problem ■

TOOTH LESS TYPE:

- Unit ■
- Partial ■
- Complete ■
- Maxillar ■
- Mandibular ■

CLINICAL EXAMINATIONS:

Exo-oral examination:

- Smile line ■
- Lips support ■

Endo-oral examination:

- Oral openning ■
- Hygiene quality ■
- Fistula, abscess, suppuration ■
- Parondontal problem ■
- Vertical bone resorption ■
- Intercrestal prosthetic space ■
- Mesiodistal width ■

Fonctional examination:

Bruxism: low ■ medium ■ high ■

Occlusion class: 1 ● 2 ● 3 ●

PLANNING:

DATE:

PRE-IMPLANTATION INVESTIGATION

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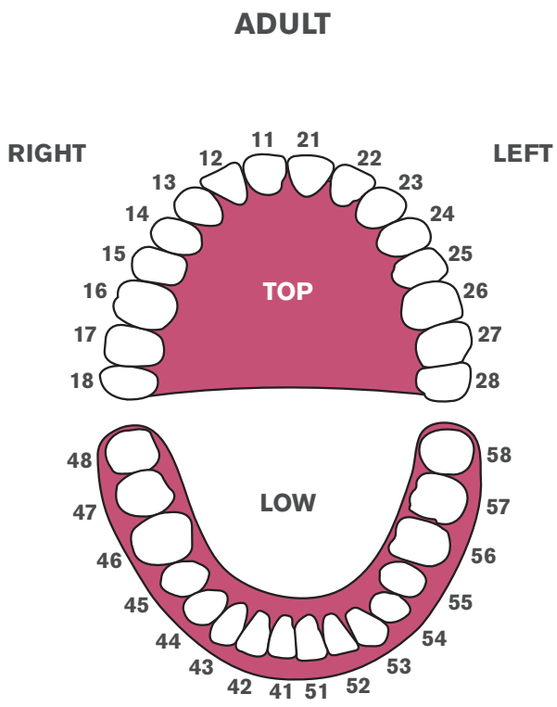

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X-RAYS EXAMINATION:

- Cysts ☐
- Periodontal pocket ☐
- Endodontic problems ☐
- Others... ☐

MESIODISTAL SPACE (S):

Area	S	Notes

AVAILABLE BONE HEIGHT (H) :

Area	H	Notes

RECOMMENDATION:

Pre-operative:

Post-operative:

PRESCRIPTION:

SURGICAL STEP

PRE-IMPLANT AND IMPLANT TREATEMENT:

Bone graft(s) :

- ☐ Autogenous — Date: / /
- ☐ Allograft(s) — Date: / /
- ☐ Xenograft(s) — Manufacturer: / Batch No.:
- ☐ Heterograft(s) — Date: / / / Type of material / origin:

Position:

- ☐ With membrane
- ☐ Without membrane
- ☐ Resorbable
- ☐ Not resorbable
- ☐ PRF

Extraction :

Date: / /

Adjustment of mucous tissue:

SURGICAL PROTOCOL:

Implant(s) and healing abutment(s) placement

Name of implanting practitioner:
National registration No.:
(if different from the practitioner responsible for follow-up indicated on page 1)

Area:

Implant and healing abutment traceability

D* ●1 ●2 ●3 ●4
RS** ●yes ●no
BD*** ●yes ●no
Torque: N.cm

Healing abutment

Ø mm

H mm

Area:

Implant and healing abutment traceability

D* ●1 ●2 ●3 ●4
RS** ●yes ●no
BD*** ●yes ●no
Torque: N.cm

Healing abutment

Ø mm

H mm

Area:

Implant and healing abutment traceability

D* ●1 ●2 ●3 ●4
RS** ●yes ●no
BD*** ●yes ●no
Torque: N.cm

Healing abutment

Ø mm

H mm

Area:

Implant and healing abutment traceability

D* ●1 ●2 ●3 ●4
RS** ●yes ●no
BD*** ●yes ●no
Torque: N.cm

Healing abutment

Ø mm

H mm

Area:

Implant and healing abutment traceability

D* ●1 ●2 ●3 ●4
RS** ●yes ●no
BD*** ●yes ●no
Torque: N.cm

Healing abutment

Ø mm

H mm

Area:

Implant and healing abutment traceability

D* ●1 ●2 ●3 ●4
RS** ●yes ●no
BD*** ●yes ●no
Torque: N.cm

Healing abutment

Ø mm

H mm

Area:

Implant and healing abutment traceability

D* ●1 ●2 ●3 ●4
RS** ●yes ●no
BD*** ●yes ●no
Torque: N.cm

Healing abutment

Ø mm

H mm

Area:

Implant and healing abutment traceability

D* ●1 ●2 ●3 ●4
RS** ●yes ●no
BD*** ●yes ●no
Torque: N.cm

Healing abutment

Ø mm

H mm

*D = Bone Density **RS = Rotational Stability ***BD = Bone Defect

TRACEABILITY INSTRUMENTATION AND CONSUMABLES

Traceability	Traceability	Traceability	Traceability
Traceability	Traceability	Traceability	Traceability

OPERATIVE REPORT

PROSTHETIC ABUTMENT(S)

LOADING: Date: / /

☐ Immediate ☐ Deferred

Duration of osseointegration period:

ABUTMENT PLACEMENT:

(screwed onto the implant, standard 1.2 mm hex connection, titanium screw)

Area:
Torque: N.cm
Traceability

Area:
Torque: N.cm
Traceability

Area:
Torque: N.cm
Traceability

Area:
Torque: N.cm
Traceability

Area:
Torque: N.cm
Traceability

Area:
Torque: N.cm
Traceability

Area:
Torque: N.cm
Traceability

Area:
Torque: N.cm
Traceability

SUPRA-IMPLANT PROSTHESIS/SES

Name of laboratory:

Phone: **Email :**

PROSTHESIS CHARACTERISTICS:

☐ Cemented crown ☐ Screwed crown
☐ Cemented bridge ☐ Screwed bridge
☐ Cemented full arch prosthesis ☐ Screwed full arch
☐ Removable full arch prosthesis
If ball abutment: ☐ 50 ☐ 60 ☐ 70 shores

Comments:

PROSTHESIS MATERIAL:

☐ Ceramo-metallic ☐ Ceramo-ceramic ☐ Resin
☐ Gold ☐ No precious

X-RAYS FOLLOW-UP

IMPLANTS PLACEMENT

Comments

X-Rays

FIRST LOADING

Osseointegration control →

Comments

Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :

FOLLOW-UP

Osseointegration control →

Comments

Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :

FOLLOW-UP

Osseointegration control →

Comments

Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :

FOLLOW-UP

Osseointegration control →

Comments

Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :
Implant in :	Implant in :

POST-TREATMENT PATIENT EVALUATION

- Very satisfied ☐
- Somewhat satisfied ☐
- Rather satisfied ☐
- Unsatisfied ☐

Comments

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