

STATUS (date):

Oral health score

Implant-related findings

Special observations

X-ray examination

Your dental office

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European Association of
Dental Implantologists

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Courtesy of



IMPLANT PASS

Last/family name

First/given name

Date of birth

Address

Postal code and city

Phone / email

Your dental office

Your dental office

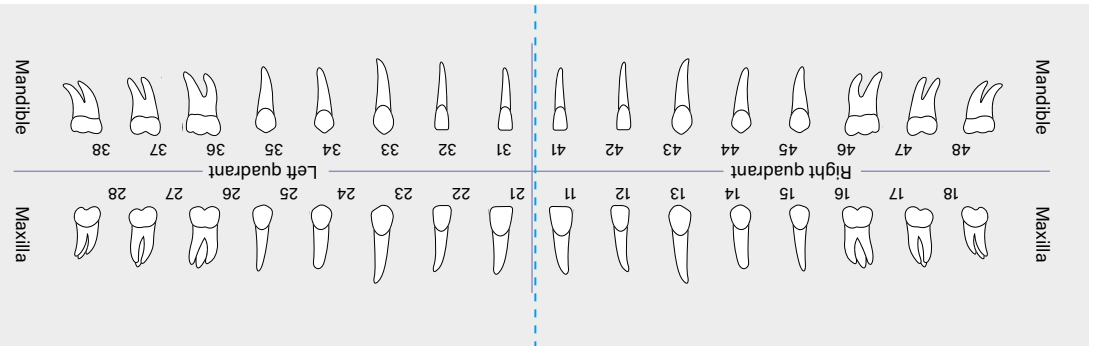
Please fold the dotted line. First this one

Date and patient's signature

This pass should be presented for all treatments, including by
other physicians or dentists.

Important diseases and allergies

I have opted for a dental treatment with implants.
I was informed in detail about the risks and benefits before
treatment. I understand that intensive oral hygiene and regular
check-ups are necessary for long-term success.
I commit to at least two dental check-ups per year and will
immediately contact my dentist at the slightest change in or
around the implants.



PROSTHODONTICS

SURGICAL PROCEDURES

Connection date:
Connection/material:

Serial number/abutment type	Implant
Serial number/abutment type	Implant
Serial number/abutment type	Implant

Placement date:
Reentry date:

Serial number/implant type	Implant
Serial number/implant type	Implant
Serial number/implant type	Implant

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