



Allograft Tracking Form

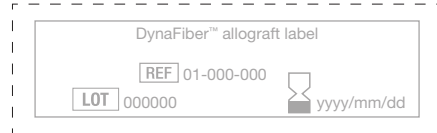
Complete this form, return it to REGENX

- MAIL a copy (folded into a standard envelope) **or** FAX a copy to 888.918.9373

Quality Department
REGENX
1034 Pearl Street, Brockton, MA 02301

Retain a copy for Patient's Records.

Affix a copy of the label included in your DynaFiber packaging



Neatly record the **REF** # _____ and the **ID** or **LOT** # _____

DOCTOR / FACILITY

Surgeon: _____

Specialty Type: Dentist • Oral/Max • Perio • Other (describe) _____

Implant Date: ___/___/___ Procedure: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Facility Phone: _____

Person Completing This Card: _____

PATIENT INFORMATION

Patient ID/MR#: _____

Patient Name: _____

Date of Birth: (Month/Day/Year) ___/___/___ Male Female

Graft Discarded (Reason for Discard) _____

