DYNA Fiber™

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)_____

_____

_____

_____

KeystoneDentalGroup