



Implant Direct LLC  
 Customer Service Center  
 26330 Diamond Place #100  
 Santa Clarita, CA 91350  
 Tel: 888-649-6425  
 Fax: 661-705-4920



www.implantdirect.com

**Implant Direct LLC ScrewIndirect Introductory Offer Clinician Form  
 GUIDELINES FOR SCREWINDIRECT IMPLANT OFFER**

- OFFER** extended to first 2000 dentists to meet requirements.
- OFFER** expires the earlier of March 31, 2009 or when 10,000 implants given away.
- OFFER** limited to North American dentists placing implants from any of the 7 major implant companies including Implant Direct.
- Only one **OFFER** per dentist, dental office, group practice or partnership regardless of whether the dentist(s) practice in multiple locations. Dentists having already received an Introductory Offer from Implant Direct prior to December 31, 2008 are still eligible for this **OFFER**.
- Dentists must identify a patient to be treated with at least 4 of the 5 ScrewIndirect implants. Dentists have 30 days from the time they register for this **OFFER** to designate the patient.
- Acceptance of this **OFFER** represents a commitment to provide Implant Direct with radiographic evidence that least 4 of the 5 implants were inserted in a patient within 30 days of receiving the free implants. Failure to comply with this requirement will require return of the 5 ScrewIndirect implants in vials with seals intact or payment of \$750, the US List Price @ \$150 each. Please email the digital radiograph to [indirectoffer@implantdirect.com](mailto:indirectoffer@implantdirect.com) or fax a legible copy to 661-705-4920.

Clinician Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Implant System Used:  Implant Direct Customer Prior To December 2008

Implant Direct	<input type="checkbox"/>	Nobel Biocare	<input type="checkbox"/>	Zimmer Dental	<input type="checkbox"/>	Straumann	<input type="checkbox"/>
Other _____		3I	<input type="checkbox"/>	Astra	<input type="checkbox"/>	BioHorizons	<input type="checkbox"/>

**Fax copy of invoice showing implant purchase from one of these competitor companies.**

Patient Name or Number: \_\_\_\_\_

**If Patient not yet selected, complete Form and submit name prior to product shipment**

**Treatment Planned**

Lower Jaw		Upper Jaw	
Immed. Insertion <input type="checkbox"/>	Fully Edentulous <input type="checkbox"/>	Immed. Insertion <input type="checkbox"/>	Fully Edentulous <input type="checkbox"/>

Patient Sex:  M  F Patient Age: \_\_\_\_\_

Proposed Date Of Surgery: \_\_\_\_\_

*I have read and agree to abide by these guidelines for receipt of this free ScrewIndirect implant offer.*

Clinician Signature: \_\_\_\_\_

Please print and fax this form to 661-705-4920

**Internal Use Only:** Registration Approved By: \_\_\_\_\_ Date: \_\_\_\_\_