sientra®

SIENTRA SILICONE GEL BREAST IMPLANT DEVICE TRACKING AND LIMITED WARRANTY ENROLLMENT FORM

PLEASE SEND FORM VIA EMAIL: ENROLLMENT@SIENTRA.COM or FAX: 888.906.0101

IMPORTANT **Please complete section 1 of this form to comply with Sientra's Device Tracking Program. ALL REQUIRED FIELDS MUST BE COMPLETED FOR DEVICE TRACKING. Please see Section 2 below for patient enrollment in the Sientra Warranty Program.**

1. DEVICE AND SURGERY INFORMATION (ALL INFORMATION REQUIRED)

PATIENT'S LEFT SIDE Place LEFT Patient Record label here or write in below:		PATIENT'S RIGHT SIDE Place RIGHT Patient Record label here or write in below:	
CATALOG # (REQUIRED)	SIZE / VOLUME	**CATALOG #** (REQUIRED)	SIZE / VOLUME
SERIAL # (REQUIRED)		**SERIAL #** (REQUIRED)	
PRODUCT NAME		PRODUCT NAME	
Record Reason for Surgery and Date of Implantation below:		**Record Reason for Surgery and Date of Implantation below:**	
REASON FOR SURGERY (REQUIRED) ☐ AUGMENTATION ☐ RECONSTRUCTION ☐ REPLACEMENT		**REASON FOR SURGERY** (REQUIRED) ☐ AUGMENTATION ☐ RECONSTRUCTION ☐ REPLACEMENT	
DATE OF IMPLANTATION (mm/dd/yyyy) (REQUIRED)		**DATE OF IMPLANTATION (mm/dd/yyyy)** (REQUIRED)	

IMPORTANT **Patients must participate in Sientra's Device Tracking Program in order to activate the Sientra Product Limited Warranty. Please complete sections 2-3, (and 4, if applicable) of this Form. ALL REQUIRED FIELDS MUST BE COMPLETED FOR LIMITED WARRANTY ACTIVATION. Please refer to the terms, conditions and claims procedures of the Limited Warranty and Product Replacement Programs for Sientra Silicone Gel Breast Implants available at sientra.com/resources or by calling 888.708.0708.**

2. PATIENT INFORMATION

☐ Patient Refused to Release Patient Identifying Information*

*If box has been checked, Sientra Product Limited Warranty will not be activated and Patient will be ineligible. (Non-Patient specific information must still be collected.)

LAST NAME (REQUIRED)		**FIRST NAME** (REQUIRED)	M.I.
TELEPHONE (REQUIRED)	CELL PHONE	FAX	EMAIL
ADDRESS (REQUIRED)			**DATE OF BIRTH (mm/dd/yyyy)** (REQUIRED)
CITY (REQUIRED)	**STATE** (REQUIRED)	**ZIP CODE** (REQUIRED)	COUNTRY

3. IMPLANTING / EXPLANTING PHYSICIAN INFORMATION

LAST NAME (REQUIRED)	**FIRST NAME** (REQUIRED)	
TELEPHONE	FAX	EMAIL
ADDRESS		
CITY	STATE	ZIP CODE

☐ The surgeon who implanted this device complied with FDA requirements pertaining to use of the Patient Decision Checklist for this device, including pre-operative review and appropriate initials and signatures. (To be completed by implanting physician)

4. FOLLOW-UP PHYSICIAN INFORMATION **If different than above** (e.g. primary care provider) ☐ **N/A**

LAST NAME	FIRST NAME	
TELEPHONE	FAX	EMAIL
ADDRESS		
CITY	STATE	ZIP CODE

FORM COMPLETED BY: _____ (SIGNATURE): _____

(DATE): _____ (TELEPHONE): _____ (FAX): _____ (EMAIL): _____

DEVICE TRACKING AND LIMITED WARRANTY ENROLLMENT FORM