ENROLLMENT FORM

SIENTRA SILICONE GEL BREAST IMPLANT DEVICE TRACKING AND LIMITED WARRANTY

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

IMPORTANT *Please Note: Patients must participate in Sientra's Device Tracking Program in order to activate the Sientra Product Warranty. Please complete section 2 of this form, all fields not marked optional must be completed for warranty activation.

1. DEVICE AND SURGERY INFORMATION

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:	
REF #	SIZE / VOLUME	REF #	SIZE / VOLUME
SN		SN	
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 ☐ AUGMENTATION ☐ RECONSTRUCTION ☐ REPLACEMENT		REASON FOR SURGERY ☐ AUGMENTATION ☐ RECONSTRUCTION ☐ REPLACEMENT	
DATE OF IMPLANTATION (mm/dd/yyyy)		DATE OF IMPLANTATION (mm/dd/yyyy)	

2. PATIENT INFORMATION*

☐ Patient Refused to Release Patient Identifying Information

(Non-Patient specific information must still be collected. All fields not marked optional must be complete.)

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

3. IMPLANTING / EXPLANTING PHYSICIAN INFORMATION

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

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): ______________

MDC-0005 R2