

Your Prevention Plan



Name:

Date:

Your dental health



What you need to do:

Your next appointments

Date:

Time:

Date:

Time:

Date:

Time:

Your dental health



Tooth decay

You have active tooth decay ☐

You are at risk of needing a filling in the future ☐

You have no active tooth decay ☐

Gum health

You need treatment from us and better cleaning by you ☐

Your gum health is stable but you need to follow our advice on cleaning ☐

You have healthy gums! Keep doing what you are doing ☐

Other problems of the mouth

You need dental treatment/referral ☐

You do not need additional treatment but we will review you regularly to monitor ☐

You have no other dental need to be concerned about ☐

What we will do for you

- ☐ Advice on what to eat or drink to improve your oral health
- ☐ Advice and demonstration on cleaning your teeth
- ☐ Smoking cessation advice and referral as agreed
- ☐ Apply fluoride varnish (and fissure sealant if required)
- ☐ Dental treatment as agreed
- ☐ Advice on fluoride use & prescription for a high fluoride toothpaste or rinse
- ☐ Other: specify _____

What we expect you to do/continue doing



Brush twice per day, at night and one other time. Spit don't rinse.



Use a family fluoride toothpaste (1,350 - 1,500 ppm fluoride)



Keep sugary food and drinks to mealtimes. Don't eat or drink anything sugary in the hour before bed.



Use support from Help Me Quit 0800 085 2219
www.helpmequit.wales



Use interdental brushes as shown and advised.



Attend your appointments when advised. Inform the practice if you cannot attend.

We have agreed that we will review progress you have made in your prevention plan in: _____ months

We have also agreed that we will do another full assessment including 'check-up' after 12 months: