



Your personal prophylaxis card

Last name

First name

Date of birth

House No./Street

Town or City/Postcode

Oral hygiene recommendations

The recommendations of your prophylaxis team:

Brush: Electric Normal

Toothbrush: _____

Toothpaste: _____

Cleaning of interdental spaces:

Floss Brush sticks Interdental brushes

Additional measures:

Chlorhexidine preparations Fluoride preparations

Other recommendations:

1st session

Day/

Date

Time

Planned treatment: _____

Comments: _____

2nd session

Day/

Date

Time

Planned treatment: _____

Comments: _____

3rd session

Day/

Date

Time

Planned treatment: _____

Comments: _____

4th session

Day/
Date

Time

Planned treatment: _____

Comments: _____

5th session

Day/
Date

Time

Planned treatment: _____

Comments: _____

6th session

Day/
Date

Time

Planned treatment: _____

Comments: _____

7th session

Day/
Date

Time

Planned treatment: _____

Comments: _____

8th session

Day/
Date

Time

Planned treatment: _____

Comments: _____

9th session

Day/
Date

Time

Planned treatment: _____

Comments: _____

10th session

Day/

Date

Time

Planned treatment: _____

Comments: _____

11th session

Day/

Date

Time

Planned treatment: _____

Comments: _____

12th session

Day/

Date

Time

Planned treatment: _____

Comments: _____

13th session

Day/
Date

Time

Planned treatment: _____

Comments: _____

14th session

Day/
Date

Time

Planned treatment: _____

Comments: _____

15th session

Day/
Date

Time

Planned treatment: _____

Comments: _____



Practice stamp