Health Risk Assessment Form

LIBERTY DENTAL PLAN

Adult Form

You are receiving this form because you have enrolled in a new Dental Managed Care plan, LIBERTY Dental Plan (LIBERTY). We will use this form to make sure you get needed care.

Please circle the answers that apply to you using a blue or black pen. Complete one form **for each person** in your family who is enrolled in LIBERTY. If you have questions, please call LIBERTY, toll free at **1.833.276.0850**. A representative is available to speak with you Monday through Friday, between 8:00 am and 5:00 pm. TDD/TTY users should dial **1.877.855-8039**.

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Member's Name:	**Date of Birth:**

ID Number:		**Please check one:**		
		Yes	**No**	**N/A**
1.	**Has it been more than 12 months since your last dental visit?**			
2.	**Do you have pain when eating cold, hot, or sugary foods?**			
3.	**Do you have painful tooth eruption?**			
4.	**Do you have an infected tooth or teeth?**			
5.	**Do you have a broken tooth or teeth?**			
6.	**Is your mouth dry?**			
7.	**Do your gums bleed when you brush or floss?**			
8.	**Have you had any gum (periodontal) treatments?** *If yes, date of last treatment:* _____			
9.	**Do you wear dentures or partials?**			
10.	**Are you currently receiving radiation or chemotherapy?**			
11.	**Are you pregnant?**			
12.	**Do you see a doctor regularly for a chronic medical condition?** *If yes, circle all that apply:* Cancer Diabetes Kidney Disease Other: _____ _____			
13.	**Do you have or associate yourself with a mental or physical disability?**			

Please return the completed form using the enclosed prepaid envelop or mail to:
LIBERTY Dental Plan, PO Box 26110, Santa Ana, CA 92799-9547.

If you think you need to see a dentist before LIBERTY contacts you, please contact your dental office or seek care from a hospital.

I understand that this information will be disclosed to my new dental plan.

Signature:	**Date Signed:**

Health Risk Assessment Form

LIBERTY DENTAL PLAN

Child Form

You are receiving this form because you have enrolled in a new Dental Managed Care plan, LIBERTY Dental Plan (LIBERTY). We will use this form to make sure you get needed care.

Please circle the answers that apply to you using a blue or black pen. Complete one form **for each person** in your family who is enrolled in LIBERTY. If you have questions, please call LIBERTY, toll free at **1.833.276.0850**. A representative is available to speak with you Monday through Friday, between 8:00 am and 5:00 pm. TDD/TTY users should dial **1.877.855-8039**.

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Member's Name:	**Date of Birth:**

ID Number:		**Please check one:**		
		Yes	**No**	**N/A**
1.	**Child has a dental home/receives regular dental care?**			
2.	**Child has teeth brushed daily?**			
3.	**Do you live in an area with fluoridated drinking water?**			
4.	**Does child snack between meals?**			
5.	**Child often drinks soda, juices, or energy drinks?**			
6.	**Is English your child's primary language?**			
7.	**Child has cavities?**			
8.	**Mother/primary caregiver has active cavities?**			
9.	**Child has special health care needs?**			
10.	**Child has plaque on teeth?**			
11.	**Child is put to bed with a bottle containing natural or added sugar?**			

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LIBERTY Dental Plan, PO Box 26110, Santa Ana, CA 92799-9547.

If you think you need to see a dentist before LIBERTY contacts you, please contact your dental office or seek care from a hospital.

I understand that this information will be disclosed to my new dental plan.

Signature:	**Date Signed:**