



Filling out this form is voluntary. The member will not be denied care based on your answers. This information is private.

Member's Name:	Date of Birth:	ID Number:
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Please check one:

1. Does the member have a dentist that they see often? ..... Yes  No
2. Does the member brush their teeth every day? ..... Yes  No
3. Does the member's teeth hurt when eating cold, hot, or sugary foods? \* ..... Yes  No
4. Does the member live in an area with fluoridated drinking water? ..... Yes  No
5. Does the member snack between meals? ..... Yes  No
6. Does the member drink a lot of soda, juices, or energy drinks? ..... Yes  No
7. Does the member have cavities? \* ..... Yes  No
8. Does a parent or guardian have a history of cavities? ..... Yes  No   
If yes, relation(s): \_\_\_\_\_
9. Does the member's teeth look like they have filmy matter called plaque? \* ..... Yes  No
10. Does the member go to bed with a bottle of milk, juice, or other drink? \* ..... Yes  No
11. Is the member pregnant? ..... Yes  No
12. Does the member see a doctor often for a serious medical condition? ..... Yes  No   
If yes, select all that apply:  cancer  diabetes  kidney disease  other: \_\_\_\_\_
13. Does the member have special health care needs? ..... Yes  No
14. Has the member been told that they have a mental, behavioral, or physical disability? .... Yes  No
15. Has the member gone to the emergency room for dental problems in the past year? ..... Yes  No   
If yes, explain: \_\_\_\_\_
16. Are there any non-medical/social conditions that would affect the member's ability to obtain care? ..... Yes  No   
If yes, select all that apply:  food  housing  transportation  other: \_\_\_\_\_
17. Is English the main language spoken at home? ..... Yes  No   
If not, what language is spoken: \_\_\_\_\_
18. I consent to receive text/email messages from LIBERTY Dental Plan to help manage my oral health. .... Yes  No   
Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

*\*If you have pain, swelling, bleeding, or infection please contact LIBERTY for immediate assistance.*

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the enrollee, please select one:  Parent of minor  Guardian  Other representative

Please return to: LIBERTY Dental Plan, P. O. Box 26110, Santa Ana, CA, 92799-6110