LIBERTY DENTAL PLAN

Child Oral Health Risk Assessment Form

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:

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. Do 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. Do 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