

52 12/28/2023

Adult Oral Health Risk Assessment Form

Filling out this form is voluntary. You 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. Has it been more than 12 months since you last saw a dentist?Yes No
2. Do your teeth hurt when eating cold, hot, or sugary foods?* Yes No
3. Do you have pain in your mouth or gums? *..... Yes No
4. Do you have an infected tooth or teeth? * Yes No
5. Do you have a broken tooth or teeth? * Yes No
6. Is your mouth dry? Yes No
7. Do your gums bleed when you brush or floss? * Yes No
8. Have you had any gum (periodontal) treatments? Yes No
If yes, list the last visit date: _____
9. Do you wear full or partial fake teeth? Yes No
10. Are you pregnant? Yes No
11. Do you see a doctor often for a serious medical condition? Yes No
If yes, select all that apply: Cancer Diabetes Kidney Disease Other: _____
12. Are you currently receiving radiation or chemotherapy? Yes No
13. Do you have or have been told that you have a mental, behavioral,
or physical disability? Yes No
14. Have you been to the emergency room for dental problems in the past year? Yes No
If yes, explain: _____
15. 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: _____
16. Is English the main language spoken at home? Yes No
If not, what language is spoken: _____
17. I consent to receive text/email messages from LIBERTY Dental Plan to help manage ... Yes No
my oral health. Cell Phone _____ Email _____

**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: _____

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