

51 12/28/2023

Child 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. 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 Yes No
ability to obtain care? 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