SoonerSelect

LIBERTY DENTAL PLAN

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:

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 my oral health. .... Yes ☐ No ☐
    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

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