Medi-Cal Oral Health Information Form

You are receiving this form because you have enrolled in a new Dental Managed Care plan, Health Net Dental (Health Net). We will use this form to make sure you get needed care.

Please check the answers that apply to you using a blue or black pen. Complete one form **for each person** in your family who is enrolled in Health Net. If you have questions, please call Health Net toll-free at **1-844-233-4522**. A representative is available to speak with you Monday through Friday, between 8:00 am and 5:00 pm. TDD/TTY users should dial **711**.

Filling out this form is voluntary.
You will not be denied care based on your confidential answers.

Member's Name:	Date of Birth:	Medi-Cal ID Number:

	Question	Please check one: Yes	No	N/A
1.	Has it been more than 12 months since your last dental visit?			
2.	Do you have pain when eating cold, hot, or sugary foods?			
3.	Do you have a painful tooth eruption?			
4.	Do you have an infected tooth or teeth?			
5.	Do you have a broken tooth or teeth?			
6.	Is your mouth dry?			
7.	Do your gums bleed with you brush or floss?			
8.	Have you had any gum (periodontal) treatments? *If yes, date of last treatment:*			
9.	Do you wear dentures or partials?			
10.	Are you currently receiving radiation or chemotherapy?			
11.	Are you pregnant?			
12.	Do you see a doctor regularly for a chronic medical condition? *If yes, check all that apply:* ☐ Cancer ☐ Diabetes ☐ Kidney Disease ☐ Other:			
13.	Do you have or associate yourself with a mental or physical disability?			

Please return the completed form using the enclosed prepaid envelope or mail to:
Health Net Dental, Attn: Case Management, PO Box 2182 Milwaukee, WI 53201-2182.

If you think you need to see a dentist before Health Net contacts you, please contact your dental office or seek care from a hospital.

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

Signature:	Date Signed: