NEW MEMBER SURVEY

In order to provide the best care possible, please answer the questions below. Complete a survey for each Florida State Medicaid Dental Health Program member in your family. Mail the completed form(s) back to mailing address listed below. Additional new member surveys can be downloaded from www.DentaQuest.com.

Your Dental History

Member Name: _____

Medicaid ID Number: _____

1. How would you rate your overall oral health?

- ☐ Very poor
- ☐ Poor
- ☐ Average
- ☐ Good
- ☐ Very good

2. How often do you

a. Brush and floss your teeth?

b. Have sugary drinks?

c. Do you have City water or Well water?

3. Do you have dental home and when was your last dental visit?

☐ Yes ☐ No

If yes, Month: _____ Year: _____

4. What did the dentist do at your appointment? Check all that apply.

- ☐ Check-up (exam and X-rays)
- ☐ Cleaning
- ☐ Fillings
- ☐ Tooth ache
- ☐ Root Canal/Crown
- ☐ Dentures
- ☐ Other _____

5. Have you visited the Emergency Department in the last 12 months for dental related problems?

☐ Yes ☐ No

If yes, please explain:

_____

6. Are you currently experiencing any tooth pain or other dental issues?

☐ Yes ☐ No

If yes, can we contact you to assist with scheduling an appointment?

☐ Yes ☐ No

best number to reach you: _____

best time/day to reach you: _____

Other Medical Conditions

We care about our member's health from head to toe. Chronic medical conditions could affect your oral health.

7. Do you have any chronic medical conditions or are you pregnant?

☐ Yes ☐ No

8. If yes, please indicate which chronic condition

- ☐ Pregnant
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Cancer
- ☐ Behavioral Health/Substance Use
- ☐ Other _____

Other Needs

9. Do you need help getting the care you need?

☐ Yes ☐ No

10. If yes, what are the problems that prevent you from getting care? Check all that apply.

- ☐ Transportation
- ☐ Language
- ☐ Housing
- ☐ Utilities (electricity)
- ☐ Food
- ☐ Other _____

11. What State Medicaid Managed Care plan are you with?

_____

12. Who is your Primary Care Provider?

_____

Mail this form to:

DentaQuest
ATTN: Case Management
8300 NW 53rd Street, Suite 200
Doral, FL 33166

DentaQuest®