# Health Risk Assessment Form

**Please answer the following questions for each member of your household:**

**► The attached form must be completed and returned in the enclosed envelope.**

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|---|---|
| Name of the person completing this form: | |
| May we have your permission to contact you if we have any questions? Yes ☐ No ☐ | |
| Member Name: | Member ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐ |
| Telephone Number: ☐☐☐☐☐☐☐☐☐☐ | Primary Language Spoken: |
| 1. Does this member have a Primary Care Physician (PCP) ? ☐ Yes ☐ No | |
| a) This member had a PCP visit in the last 3 months. ☐ Yes ☐ No | |
| b) This member had a routine physical in the last 3 months. ☐ Yes ☐ No | |
| c) Would this member like to be contacted to identify a participating doctor. ☐ Yes ☐ No | |
| 2. Does this member have a dentist they see regularly? ☐ Yes ☐ No | |
| a) Has this member had an emergency dentist visit in the last 3 months. ☐ Yes ☐ No | |
| b) Has this member had a scheduled routine dental exam in the last 3 months ☐ Yes ☐ No | |
| c) Would this member like to be contacted to identify a participating dentist. ☐ Yes ☐ No | |
| 3. Does this member use medical equipment, such as wheelchair or oxygen, in the home? ☐ Yes ☐ No If yes, what? | |
| 4. Has this member been hospitalized in the last year? ☐ Yes ☐ No | |
| 5. Has this member been to the Emergency Room (ER) 3 or more times in the last 6 months? ☐ Yes ☐ No | |
| 6. What conditions has this member been treated for or are currently being treated for:<br>☐ Alcohol Abuse ☐ Mental Health Problems ☐ Substance Abuse Problems ☐ HIV/AIDS ☐ Transplant ☐ Sickle Cell<br>☐ Asthma ☐ Congestive Heart Failure ☐ Diabetes ☐ Cancer ☐ Other Medical Problems | |
| 7. Is this member currently pregnant? ☐ Yes ☐ No If yes, please answer the following: | |
| a) What is the name of this member's doctor (OB)? | |
| b) Baby Due Date: | |
| 8. Does this member take 4 or more medicines every day? ☐ Yes ☐ No | |
| If yes, please list the medications: | |

A visit to a doctor for pregnancy care should happen within 14 days of either becoming a Peach State Health Plan member or finding out you are pregnant after you join.

If you need additional copies of this form visit our website at: pshp.com or contact the Member Services department at **1-800-704-1484.**