



### Health Survey Form

**Welcome to Health Plan of Nevada!** We will do our best to keep you healthy and give you quality medical care. **Please take a few minutes to fill out this form.** We want to be able to contact you and to know about your special health care needs. **Your benefits will not be reduced because you answered these questions.** If you need help filling out this form, call us at 1-800-962-8074 between 8am - 5pm, Monday - Friday.

<b>Family members enrolled in Health Plan of Nevada's Medicaid or Nevada Check Up Program are:</b>		
Adults' Name(s): 1. _____ 2. _____ 3. _____ 4. _____	Date of Birth of Adult(s): 1. _____ 2. _____ 3. _____ 4. _____	Medicaid #: 1. _____ 2. _____ 3. _____ 4. _____
Name of Child(ren): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Date of Birth of Child(ren): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Medicaid #: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
Address:		Telephone Number(s): Home: _____ Work: _____ Mobile: _____ Other: _____
The language(s) we usually speak and read at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please write here): _____		

**Please answer these questions to help us take better care of you and your family members who are enrolled in Health Plan of Nevada:** \*\* Please note these answers are confidential as governed by Federal and State Law, and will only be used to assist you with your medical care.

1. During the past year, were you or anyone in your family admitted for an overnight stay in a hospital?

No  Yes:

● Name of Person(s) Admitted:

● For what problem?

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

2. During the past year, have you or anyone in your family received medical care in a hospital emergency room?

No  Yes:

● Name of Person(s) Admitted:

● For what problem?

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

Please complete and return this form to our Case Management Team, by placing it in the provided postage paid envelope. Or mail it directly to us at: UnitedHealthcare Nevada Market, PO Box 15645, Las Vegas, NV 89195-8026.



3. Do you have a Primary Care Provider? (Example: OB/GYN or Family Medicine)  No  Yes:  
Name of your Doctor: \_\_\_\_\_

Do you see this doctor for any special healthcare problem(s)?  No  Yes:

Please check the box for the problem that applies:

- Asthma                       Cancer                                       Other (please write specific issue):
- Diabetes                       Heart Disease

4. Do your child(ren) have a Primary Care Provider? (Example: Pediatrician)  No  Yes:  
Name of your child's Doctor: \_\_\_\_\_

Does he/she see this doctor for any special healthcare problem(s)?  No  Yes:

Name of child(ren) with special healthcare problem(s): \_\_\_\_\_

Please check the box for the problem that applies:

- Asthma                       Cancer                                       Other (please write specific issue):
- Diabetes                       Heart Disease

5. Are each of your children up to date with all of their shots?  No  Yes  Not sure  
If "no" or "not sure," please list the names of the child(ren) who might need more shots:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

6. Has each child had a regular check-up with their doctor in the past year?  No  Yes  
If "no," please list the names of the child(ren) whom have not had a check-up in the past year:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

7. Are you or anyone in your family pregnant now?  No  Yes:  
If "yes," please provide the following information, include yourself if it applies:

Name: _____	Date of birth: _____	Due date: _____
Name: _____	Date of birth: _____	Due date: _____
Name: _____	Date of birth: _____	Due date: _____

8. Are you getting any dental services now?  No  Yes:  
Name of your Dentist: \_\_\_\_\_

For what problem? \_\_\_\_\_

Are your child(ren) getting any dental services now?  No  Yes:

Name of your child's Dentist: \_\_\_\_\_

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