Regence

Dental4Health Enrollment Form

Please complete the member and provider information sections below.

MEMBER INFORMATION

Please check your medical condition(s):

- ☐ COPD
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Oral cancer
- ☐ End-stage renal disease
- ☐ Head and neck cancers
- ☐ Metabolic syndrome
- ☐ Pregnancy _____ (expected delivery date)
- ☐ Stroke
- ☐ Sjögren's syndrome

Primary policyholder name: _____

Member Dental ID (located on your ID card): _____ Group #: _____

Member name: _____ Date of birth: _____

Member address: _____

City: _____ State: _____ ZIP code: _____

Member telephone #: (home) _____ (cell) _____

Member email address: _____

☐ I hereby affirm that I have been diagnosed with the condition(s) checked above.

☐ I agree to receive electronic communication about Dental4Health®.

Signature: _____ Date: _____

PROVIDER INFORMATION

Physician name (please print): _____

Physician license #: _____ State: _____

Physician phone #: _____

Physician address: _____

City: _____ State: _____ ZIP code: _____

The information you have provided will be used solely for the Dental4Health program and no other reason. Please keep a copy of this form for your records. Note that processing this form may take up to a month.

Please sign and date your completed form and mail it to:

200 SW Market Street, Suite 800

Portland, OR 97201

To find a dentist in your network, visit regencedental.com/members/find-a-dentist.
For information, call Customer Service at 1-888-675-6570.