	Wah-Zha-Zhi Health Center		
OFFICE USE	**Diabetes Program Participant Demographic Sheet**	CHART #	**2018**
MC_____	MEDICAL PROVIDER:	DIABETES TYPE: _____	

Participant information:

Name: _____ Chart #: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone #: _____ Tribal Affiliation: _____

Medicare: _____ Medicaid: _____
Health Insurance: _____

Doctor's name/clinic: _____ last visit: _____
Dentist's name/clinic: _____ last visit: _____
Eye Doctor's name/clinic: _____ last visit: _____

Please provide Diabetes Staff with copies of all current types of insurance, including Medicare, Medicaid, and Pawnee Benefit Package Program, driver's license, and membership/citizenship/degree of Indian blood of federally recognized tribe.

Privacy statement

I UNDERSTAND AND AGREE that this is a joint effort between the Osage Nation Diabetes Program and the Wah-Zha-Zhi Health Center. Relevant clinical information will be shared with clinical staff of both entities and, by signing below, I hereby acknowledge receipt of the Wah-Zha-Zhi Health Center's Notice of Privacy Practices.

Participant's signature: _____ Date: _____

Furthermore, I UNDERSTAND AND AGREE, that to be considered an active participant of the Osage Nation Diabetes Program and eligible for certain benefits, including, but not limited to self-monitoring testing supplies, I am required to follow recommendations below:

_____ I will schedule and keep, at least, one appointment per year with my medical provider for the **sole purpose** of monitoring the status of my Diabetes diagnosis.
_____ I will schedule and keep one appointment per year with the Registered Dietitian provided by the Diabetes Program.
_____ I will schedule and keep one appointment per year with the dentist of my choice for an annual Diabetic Dental Exam.
_____ I will schedule and keep one appointment per year with the optometrist of my choice for an annual Diabetic Dilated Eye Exam.
_____ I will have the diabetes-appropriate lab drawn as ordered by my medical provider at least one time per year.
_____ I will present my glucometer to the Diabetes Program for "download" at least two (2) times in a twelve (12) month period.
_____ I will have an annual diabetic foot exam completed and documented by the Diabetes Program.
_____ I will have at least one documented Diabetes Program nurse visit annually, or more as recommended by my primary care provider.

***If participant chooses to utilize any provider other than those offered by Wah-Zha-Zhi Health Center, a summary of the required visit must be provided to the Diabetes Program to remain active in the program.
***It is the participant's responsibilities to notify the Osage Nation Diabetes Program Administrative Assistant when requirements have been met.

Participant's signature: _____ Date: _____