

Intensive Diabetes Program Participant Form

Please bring to first class session

Name _____

Insurance Carrier _____

Insurance number / Group Number
_____ / _____

who is primary insurance holder in family/relationship to the insured?
_____ / _____

if the primary insurance holder has different address and phone,
please provide

Participant's Date of Birth _____

Spouse's name and date of birth, if attending program _____

Home Address _____

E-mail address

Day/evening phone no. _____ / _____
***Circle phone # to call for last minute class cancellation**

Primary care physician and address

Endocrinologist and address _____

How did you hear of the Intensive Diabetes Program?
 Physician Flyer/Letter in mail
 Friend Newspaper ad
 Website
Other _____

Year diagnosed with high blood sugar _____

The information provided above is to accurate and truthful. I understand that the Intensive Diabetes Program is not responsible for any potential health complications I may have as my unique health situation(s) may not be addressed by this program.

Signature _____ Date _____