

Please print clearly, answer all questions, sign and return in the enclosed business-reply envelope.

NAME

\_\_\_\_\_

*Last* *First*

PHONE NO. (home) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*Area Code*

ADDRESS

\_\_\_\_\_

*Street or P.O. Box*

PHONE NO. (work) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*Area Code*

CITY \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ GENDER:  F  M

*State Zip*

DATE OF BIRTH \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-MAIL AVAILABILITY:  Yes  No

*Month Day Year*

HEALTH INSURANCE ID CARD NO. \_\_\_\_\_

*(This will be your ID number for this program)*

E-MAIL ADDRESS\* \_\_\_\_\_

*\*This is optional, but by giving us your e-mail address, you allow us to send you additional information about the Diabetes Education Program.*

PHYSICIAN NAME

\_\_\_\_\_

*Last* *First*

ADDRESS

\_\_\_\_\_

*Street or P.O. Box*

CITY \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*State Zip*

Please answer these simple questions by filling in the correct answer. Your answers will be used to improve the health information we may send you in the future.

1. How long have you had diabetes? \_\_\_\_\_ years  Less than 1 year  I don't know
2. Please check the type of diabetes  Type 1  Type 2  I don't know
3. Check each thing that now is part of your treatment:
 

<input type="checkbox"/> Food or diet plan	<input type="checkbox"/> Diabetes pills	<input type="checkbox"/> Both insulin and pills
<input type="checkbox"/> Exercise	<input type="checkbox"/> Insulin	<input type="checkbox"/> Blood testing
		<input type="checkbox"/> Not sure / not listed
4. Have you gone to a hospital or emergency room for your diabetes in the past year?
 

Yes  No  I don't know
5. Do you smoke or use other forms of tobacco?  Yes  No
6. Do you have foot or leg problems because of your diabetes?  Yes  No  
(This includes problems like open sores, pain, tingling, loss of feeling, or surgery.)
7. Please record your **most recent** fasting blood sugar reading: \_\_\_\_\_ (Example: 150)  I don't know
8. Please record your **most recent** hemoglobin A1C (HgbA1C) reading: \_\_\_\_\_ (Example: 7)  I don't know

**(Continued on other side)**

9. What is your current weight? \_\_\_\_\_ lbs.      What is your current height? \_\_\_\_\_ feet \_\_\_\_\_ inches  
(Example: 5 feet 6 inches)
10. How many days of work did you miss last year due to an illness related to your diabetes?  
 0 days       1-3 days       4-5 days       More than 5 days       Not working
11. How many days a week do you exercise for at least 30 minutes without stopping  
(example: walking, cycling, swimming — include taking stairs, etc.)?  
 0 days       1 day a week       3 days a week       5 days a week       Every day

We are very interested in providing you with information regarding self-management of diabetes. Please list below any topics that you would like to see included in the Diabetes Education Program materials.

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The Diabetes Education Program is for health education purposes only. We do not offer medical advice or medical services. Members always should consult their treating physician(s) for any medical advice or services. The member is responsible for selecting providers, services or products. **All referenced health services may not be covered under a health plan. Please check the terms of your health plan or insurance policy for coverage of services.** Information furnished by a member is kept strictly confidential and only used to provide information necessary for participation in or analysis of the Diabetes Education Program.

**By my signature**, I hereby indicate my decision to enroll in the Diabetes Education Program. I understand that there is no cost to me or my family for this program. I further authorize Arkansas Blue Cross and Blue Shield, Health Advantage and Blue Advantage to release my name and address for the purpose of my participation in mailings from the Diabetes Education Program. My information will not be furnished to third parties to include in shared mailing lists with other companies or organizations.

Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

# Welcome to the program!



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association  
[arkansasbluecross.com](http://arkansasbluecross.com)



**Health Advantage**  
An Independent Licensee of the Blue Cross and Blue Shield Association  
[healthadvantage-hmo.com](http://healthadvantage-hmo.com)



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Administrators of Arkansas**  
An Independent Licensee of the Blue Cross and Blue Shield Association  
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