Community Health Representative CHR Fax: 580/654-2971

Special Diabetes Fund

KIOWA DIABETICS ONLY DATE_____

SPECIAL DIABETES PROGRAM - *DENTURE* APPLICATION

NAME:_____
First Middle Last

ADDRESS:_____
Box/Street City Zip Code

TELEPHONE:_____ Date of Birth: _____

KIOWA CDIB #:_____

Any Diabetes information received might be verified by CHRs

Are you a Diabetic? ☐ Yes ☐ No

What medications are you taking for your diabetes?

_____

_____

_____

Which Indian Health Service Facility do you receive your Diabetes Care? Check One

Lawton PHS☐ Anadarko Indian Clinic ☐ Carnegie Indian Clinic ☐ _____ ☐

Date of last Diabetic Appointment:_____

Date of Diabetic Dental Exam:_____

Which type of Dental Service do you need? Upper/Lower/Partial or Full Set (explain):

_____

_____

Applicant Signature:_____

CHR Signature:_____

(revised 2017)