The purpose of this article is to present a primary care clinic with a multidisciplinary staff that includes a general practitioner, a diabetes nurse, a nutritionist, a social worker, and a pharmacist; in comparison to a general practitioner, who receives no assistance from a multidisciplinary team, in his attempt to balance diabetes parameters. The work at a clinic that employs a multidisciplinary team includes the tracking of the patients’ condition, performed by a diabetes nurse, who also ensures periodical testing. Computerized management of patient records allows the clinic to continuously track the patients’ conditions, follow-up tests, medication purchases, and treatment results. All the information from the treatment progress records on diabetes patients belonging to that clinic is electronically fed to the treating physician, who holds periodic meetings with the clinic’s staff, mostly concerning patients who fail to meet the recommended treatment goals. A comparison between the data of the diabetes patients of a clinic with a multidisciplinary staff, from the year 2013; and that of the patients of a primary care physician, with no supporting staff; shows the distinct advantage of the clinic, in most areas. Finally, diabetes as a progressive and chronic disease requires: follow-up, refresh knowledge and supports a large number of patients. For these reasons, multidisciplinary teamwork at the primary care, community clinic provides substantial benefits to the process of balancing the diabetes’ patients’ condition.