ADVANCE HEALTH CARE DIRECTIVE

Dear Patient,

As your physician, we are required to ask any patient over the age of 18, if they have an existing Advance Health Care Directive, so that we can incorporate the information into your medical record. You are not required to give us this information, but we are required to ask. Please complete this form, and return to the receptionist. Thank You.

PATIENT NAME _____ SS# _____
(Please Print)

PATIENT SIGNATURE _____ DATE _____

1.	I decline to answer these questions	Yes ☐ No ☐
2.	Do you have an Advance Health Care Directive?	Yes ☐ No ☐
3.	If Yes, please indicate which type of Directive.	
	Durable Power of Attorney for Health Care	☐
	California Natural Death Act	☐
	Living Health Care Will	☐
	Other _____	☐
4.	Will you bring us a copy of your Directive?	Yes ☐ No ☐

Internal Office Use Only

Type of Health Care Directive Received:		**Date Received:**
Durable Power of Attorney for Health Care	☐	_____
California Natural Death Act	☐	_____
Living Health Care Will	☐	_____
Other: _____	☐	_____