Advanced Health Care Directive
(California Probate Code Sec.4701)

Dear Patient:

As your Primary Care Physician's office, we are required to ask any patient over the age of 18 if they have an existing Advanced 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 it to the front office staff. Thank you.

Do you have an Advanced Health Care Directive? ☐Yes ☐No

If yes, please indicate which type of Directive:

- ☐ Durable Power of Attorney for Health Care
- ☐ California Natural Death Act
- ☐ Living Health Care Will
- ☐ Any Other

Would you like us to furnish you with a blank Advanced Health Care Directive Form? ☐ Yes ☐ No

Will you be providing us with a copy of your Advanced Health Care Directive? ☐ Yes ☐ No

Patient Name: _____

Patient Signature: _____ Date: _____

I Decline to answer these questions. I have been offered an Advance Health Care Directive and I refuse at this time.

Patient Signature: _____ Date: _____

Internal Office use Only

Type of Health Care Directive Received	Date Received	Initials
☐ Durable Power of Attorney for Health Care	_____	_____
☐ California Natural Death Act	_____	_____
☐ Living Health Care Will	_____	_____
☐ Any Other	_____	_____
☐ This Patient Refused an Advanced Health Care Directive Form	_____	_____