Norfolk Family Medicine, P.C.
900 W Norfolk Ave
Suite 100
Norfolk, NE 68701

ADVANCE DIRECTIVE QUESTIONNAIRE

PATIENT: ______________________

1. Do you have a durable power of attorney for healthcare? Yes __ No __
   If yes, who is it: Name ________________________
   Address: _____________________
   ____
   Telephone: ____________________

2. Do you have a living will? Yes __ No __
   If no, would you like more information about a living will/durable power of attorney for healthcare? Yes ___ No ___
   If you do have a living will, do you have a copy with you? Yes __ No __
   (If you do have a living will/durable power of attorney, please provide this office with a copy of your directives)

This physician's office has asked me about the above information and has offered further information if desired.

Patient signature: ________________________________
Date: ____________________

This information will be contained in your medical record for future reference. If the status of the above information changes for any reason, it is your responsibility to inform us of any changes so that we may have you complete a new Advance Directive Questionnaire.