BRONSON

Affix Patient Label

Name_____ Date of Birth_____

Bronson Physician Practices

Advance Directive Questionnaire

1. Do you have an advance directive?

   If yes-I was instructed to provide a copy to the office for placement in my chart. Yes ☐ No ☐

2. If you do not have an advance directive, would you like further information?

   If yes-An information packet was provided to me including: Yes ☐ No ☐

   - Designation of Patient Advocate Form
   - Advance Directive Information for Patients (Q&A)

_____ _____
Print Name DOB

_____ _____
Patient Signature Date