Catholic Health Services of Long Island
At the heart of health

Siena Proactive Internal Medicine – Smithtown

Patient Name: _____Today's Date _____

(Please Print)

Patient's Date of Birth: _____

Please circle your answers:

1. Do you have a Health Care Proxy or a Legal Guardian? **YES or NO**
    a. If YES, please print their name below:

_____ _____

(Health Care Proxy/Legal Guardian Name) (Contact Phone Number #)

2. Do you have a Primary Care Giver (someone who provides day-to-day care, and receives instructions about your care)? **YES or NO**
    a. If YES, please print their name and contact number below:

_____ _____

(Primary Care Giver Name) (Contact Phone Number #)

3. Do you have an Advanced Directive (example: Living Will, Power of Attorney, etc.)? **YES or NO**
    a. If YES, please bring a copy with you to put into your chart at your next visit.

***Health Care Proxy forms are available – Please ask one of our staff members if you are interested.