

Please return this completed form to:

**T. Walton Dallas, P A
130 Riverview Drive, Suite A
Flowood, MS 39232-8921
Bonnie' Phone: (769) 798-2123
Tom's Phone (601)209-1601
Fax: (800) 861-1498**

Health Care Directive Questionnaire

1. Your full name _____
2. Your phone number _____ - _____ cell / work / home
3. Your e-mail address _____
4. Your spouse's full name _____
5. Your street address _____
6. Your city, state and zip code _____
7. Your county of residence _____
8. Children. List the full names and dates of birth of your children (state if from a different marriage):
 - a. _____
 - b. _____
 - c. _____
 - d. _____
9. List your Health Care Agent and alternates (list on same line if to serve together, use "or" if any one of them can take action; use "and" to require all to take action).
 - a. _____
 - b. _____
 - c. _____
10. If in a state of hopelessness:
 - a. do you want the plug pulled? Yes No
 - b. receive food and drink? Yes No Discretion of Agent
11. Medicine for alleviation of pain? Yes No
12. Do you wish to be cremated? Yes No
13. Donate organs for transplantation? Yes No
14. Donate organs for Scientific Research? Yes No
15. Your primary physician (optional). _____
16. Special Instructions _____

17. For a Married Couple fill out the other side for the other Spouse.