Healthcare Proxy Registration Form

Date: _____

Patient Information

Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Healthcare Proxy Information

Name of Proxy: _____

Relationship to Patient: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Signature

I, _____, hereby appoint the individual named above as my healthcare proxy.

Signature: _____

Date: _____

Witness Information

Witness Name: _____

Signature: _____

Date: _____