

Personal Information Form

*** All information contained in this form is confidential and protected by attorney-client privilege. ***
Completing this prior to your appointment will enable us to spend more time during the meeting to answer your questions and help you identify solutions to your concerns.

Client 1: _____ DOB: _____ US citizen Naturalized citizen resident alien
 Occupation: _____ retired employed Veteran Yes No
 Marital status: single/widow(er) married (date _____) first second other _____

Client 2 (if applicable): _____ DOB: _____ DOD (if applicable) _____
 US citizen Naturalized citizen resident alien Occupation: _____ retired employed
 first marriage second marriage other _____ Veteran Yes No

Address: _____ City: _____ State: _____ Zip Code _____

Home # _____ Cell # _____ Work # _____ e-mail address _____

Which number(s) would you prefer to be contacted at? home cell work What is best time? _____

Referred to us by: Name: _____ Firm Name: _____

Contacts: Financial Advisor _____ Firm: _____ Phone: _____
 Accountant/tax: _____ Firm: _____ Phone: _____

Existing Estate Planning:	You	Client 2 <input type="checkbox"/> NA	Date Document Executed
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Health Care Proxy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Long-Term Care Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Daily benefit: \$ _____ Term _____

Have you transferred or gifted away assets away in the last 60 months? Amount \$ _____ Date: _____

Your health status plays an important role in the designing of an estate plan best suited for you and your loved ones.

You - current health status: Good Concern Problem
 Specific concern/problem: _____

Client 2 - current health status: Good Concern Problem
 Specific concern/problem: _____

	You	Client 2
Do you have children:	<input type="checkbox"/> Yes How many? _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes How many? _____ <input type="checkbox"/> No
Please specify:	<input type="checkbox"/> joint <input type="checkbox"/> you <input type="checkbox"/> step <input type="checkbox"/> adopted <input type="checkbox"/> foster	<input type="checkbox"/> joint <input type="checkbox"/> you <input type="checkbox"/> step <input type="checkbox"/> adopted <input type="checkbox"/> foster
Do you have grandchildren:	<input type="checkbox"/> Yes How many? _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes How many? _____ <input type="checkbox"/> No

What would completing your estate planning accomplish for you? _____

What do you see as your biggest risk if you don't complete your estate plan? _____

Rank the following (1-8) in order of importance for you currently (1 = Most Important 8 = Least Important)

- | | |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| _____ Avoid probate | _____ Protect assets from govt/lawsuits/nursing homes |
| _____ Keep estate matters private | _____ Protect assets for family from predators after my death (i.e. my spouse's disability or remarriage, my children's/beneficiary's lawsuits, divorce or bankruptcy) |
| _____ Minimize/eliminate taxes | _____ Keep it simple for my family when something happens to me (disability/death) |
| _____ Remain independent and in control of my care and/or assets | _____ Provide detailed instructions and authority to people I trust to have the care I desire provided for me if I become disabled |

PERSONAL/FAMILY INFORMATION

CHILDREN (if applicable) or BENEFICIARIES (who you want to get your "stuff")

Name: _____ male female Date of Birth: _____
Address: _____ Phone: _____
Child of: joint you client 2 adopted foster child Other relation _____
 student employed - Occupation: _____
 Single Married first second other - how long? _____ spouse's name: _____ occupation: _____
Children: none How many? _____ Ages: _____
Special needs/considerations: _____
Potential problems/hardships/issues: _____

Name: _____ male female Date of Birth: _____
Address: _____ Phone: _____
Child of: joint you spouse adopted foster child Other relation _____
 student employed - Occupation: _____
 Single Married first second other - how long? _____ spouse's name: _____ occupation: _____
Children: none How many? _____ Ages: _____
Special needs/considerations: _____
Potential problems/hardships/issues: _____

Name: _____ male female Date of Birth: _____
Address: _____ Phone: _____
Child of: joint you spouse adopted foster child Other relation _____
 student employed - Occupation: _____
 Single Married first second other - how long? _____ spouse's name: _____ occupation: _____
Children: none How many? _____ Ages: _____
Special needs/considerations: _____
Potential problems/hardships/issues: _____

Name: _____ male female Date of Birth: _____
Address: _____ Phone: _____
Child of: joint you spouse adopted foster child Other relation _____
 student employed - Occupation: _____
 Single Married first second other - how long? _____ spouse's name: _____ occupation: _____
Children: none How many? _____ Ages: _____
Special needs/considerations: _____
Potential problems/hardships/issues: _____

Name: _____ male female Date of Birth: _____
Address: _____ Phone: _____
Child of: joint you spouse adopted foster child Other relation _____
 student employed - Occupation: _____
 Single Married first second other - how long? _____ spouse's name: _____ occupation: _____
Children: none How many? _____ Ages: _____
Special needs/considerations: _____
Potential problems/hardships/issues: _____

Name: _____ male female Date of Birth: _____
Address: _____ Phone: _____
Child of: joint you spouse adopted foster child Other relation _____
 student employed - Occupation: _____
 Single Married first second other - how long? _____ spouse's name: _____ occupation: _____
Children: none How many? _____ Ages: _____
Special needs/considerations: _____
Potential problems/hardships/issues: _____

Financial Information Sheet

**** It is very important you indicate in each category ownership and dollar amount separately, as well as total value.****

MONTHLY INCOME:

SOURCE	YOU	CLIENT 2	JOINT	TOTAL
Wages	\$	\$	\$	\$
Pension	\$	\$	\$	\$
Social Security	\$	\$	\$	\$
Investments	\$	\$	\$	\$
Other	\$	\$	\$	\$
Total Value	\$	\$	\$	\$

ASSET INFORMATION AS OF _____ (date) - Please provide total amount for each type of asset and who owns.

TYPE OF ASSET	YOU	CLIENT 2	JOINT	TOTAL
Cash, Checking, Savings, CD=s, Money Market & Cash Management Accounts	\$	\$	\$	\$
Investment/Broker-held Accounts (not including cash) and Mutual Fund Accounts	\$	\$	\$	\$
Retirement Accounts: IRA, 401K, 403B, SEP, etc.	\$	\$	\$	\$
Life Insurance: death benefit and cash value	D.B. \$ C.V. \$	D.B. \$ C.V. \$	D.B. \$ C.V. \$	D.B. \$ C.V. \$
Stocks: you hold (not in brokerage accounts)	\$	\$	\$	\$
Bonds: bonds you hold (not in brokerage accounts)	\$	\$	\$	\$
Annuities: \$ = original amount invested date=month/year purchased CV=current value	\$ _____ date ____ CV _____	\$ _____ date ____ CV _____	\$ _____ date ____ CV _____	\$ _____ date ____ CV _____
Real estate: residence	\$	\$	\$	\$
Real estate: other	\$	\$	\$	\$
Vehicles: automobile, motorcycle, boats, snowmobiles, etc.	\$	\$	\$	\$
Total Assets	\$	\$	\$	\$

OTHER ASSETS NOT LISTED:

TYPE	YOU	CLIENT 2	JOINT	TOTAL
	\$	\$	\$	\$
	\$	\$	\$	\$
Total Value	\$	\$	\$	\$

LIABILITIES:

TYPE	YOU	CLIENT	JOINT	TOTAL
Mortgage	\$	\$	\$	\$
Loans Payable	\$	\$	\$	\$
Other	\$	\$	\$	\$
Total Value	\$	\$	\$	\$

BUSINESS INTEREST:

TYPE	YOU	CLIENT	JOINT	TOTAL
Farm	\$	\$	\$	\$
Partnership or LLC Interest	\$	\$	\$	\$
Corporation <input type="checkbox"/> S-Corp?	\$	\$	\$	\$
Other:	\$	\$	\$	\$
Total Value	\$	\$	\$	\$

Other things you think we should know: _____
