TOOLE, POWERS & GRIFFIN, P.A.
NEW CLIENT QUESTIONNAIRE
ESTATE PLANNING/LONG TERM CARE PLANNING INFORMATION

A. **PERSONAL INFORMATION** Date_____

Your full name:_____DOB:_____SSN:_____
Address:_____
County of residence:_____ Employer:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Your spouse's full name:_____DOB:_____ SSN:_____
County of residence:_____ Employer:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
E-Mail Address:_____
Date of Marriage:_____

Children:

1._____
Full Name Age Spouse's Full Name
_____
Address City State Zip Code
_____
Home Phone Cell Phone Work Phone # of Children Children's Ages

2._____
Full Name Age Spouse's Full Name
_____
Address City State Zip Code
_____
Home Phone Cell Phone Work Phone # of Children Children's Ages

3._____
Full Name Age Spouse's Full Name
_____
Address City State Zip Code
_____
Home Phone Cell Phone Work Phone # of Children Children's Ages

4._____
Full Name Age Spouse's Full Name
_____
Address City State Zip Code
_____
Home Phone Cell Phone Work Phone # of Children Children's Ages

If more space is needed for children, please continue on the back of this page.

Do you or your spouse have any children by a previous marriage? Yes _____ No _____
Please explain:_____

Do you or your spouse have children who died leaving children? Yes _____ No _____
Please explain:_____

Does anyone to whom you may be leaving part of your estate require any help or protection in managing money or other property? Yes _____ No _____
Please explain:_____

Do you or your spouse hold any powers of appointment? _____Yes _____No
Please explain:_____

Helpers: If you were in the hospital and unable to make decisions for yourself, with whom would you want doctors to consult with about your care (list in order of priority):

1._____
Name Address Telephone
2._____
Name Address Telephone

Medical/Disability: Is anyone in your household disabled? Yes _____ No _____
Please explain:_____

Is anyone at risk for becoming seriously ill or disabled because of a medical condition or family history?
Yes _____ No _____

B. **NURSING HOME**: If either spouse is residing in a nursing home, please give us the date when the spouse first entered and the name of the nursing home. If entrance to the nursing home followed a period of hospitalization, please give the first date of hospitalization.

Nursing Home	Date of First Hospitalization

C. **LIFE INSURANCE POLICIES**: Do either you or your spouse have any life insurance polices? ***If so, please complete the following and bring a copy of the policies to your appointment***:

Company Name	Face Value	Policy owner	Beneficiary	Cash Value

D. **HEALTH INSURANCE**

Do you have Medicare? Yes _____ No _____
Does your spouse have Medicare? Yes _____ No _____
Do you have Medicare Days? Yes _____ No _____
Does your spouse have Medicare Days? Yes _____ No _____
Do you have supplemental insurance? Yes _____ No _____
Does your spouse have supplemental insurance? Yes _____ No _____
If you or your spouse has supplemental insurance, please bring the insurance card and a copy of the premium invoice to your appointment.

E. **LONG TERM CARE INSURANCE**

Do you have any Long Term Care Insurance? Yes _____ No _____
If yes, please bring the policy with you to your appointment.

Name of Company	Policy Number

F. **REAL ESTATE**: Do either you or your spouse own any real estate in your names, or jointly with another? ***If yes, please complete below and bring copies of any deeds.***

Names(s)/Address on Deed	Assessed Value	Fair Market Value*

*Your best estimate

G. **HOUSING EXPENSES**: Please itemize the following costs of your principal place of residence:

Rent, Mortgage, Condo Fee $_____/ month
Real Estate Taxes $_____/year
Homeowner's Insurance $_____/year
Do you pay for heat? Yes _____ No _____

H. **AUTOMOBILES**: Please list all automobiles, recreational vehicles, etc. owned by you and/or your spouse:

Make and Year	Name of Owner	Value

I. **STOCK, BONDS AND SECURITIES**: Do you or your spouse own any securities, stocks, bonds, money market funds (in an investment house), etc.? If so, please complete below:

Name of Security	Name of Owner(s)	Value

J. **TRUSTS**: Are you or your spouse the beneficiary of a trust? Yes _____ No _____
If yes, please bring a copy of the trust to your appointment.

K. **BANK ACCOUNTS**: Please list each bank account (including Certificates of Deposit Money Market Account in a bank) and checking accounts, owned by you or your spouse individually, jointly with your spouse or jointly with another person:

Bank	Account #	Name(s) in which account is held	Amount

L. **PENSIONS**: Please list each retirement, pension or annuity accounts owned by you or your spouse:

Bank /Pension Company	Account #	Name in which account is held	Amount	Beneficiary (if any)

Please bring copies of any retirement plan, pension plan or annuity to your appointment

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M. **OUTSTANDING LOANS/MORTGAGES**: Do you or your spouse owe any large bills or have any outstanding loans or mortgages? If so, please identify:

Creditor	Name(s) of Debtor(s)	Balance

N. **OTHER ASSETS**: Other than household items, clothing, jewelry and those items listed in questions A – L, do you or your spouse own anything else of any value? If so, please specify below:

_____
_____
_____
_____
_____

O. **INCOME**: Please describe your monthly income, and if applicable, your spouse's income. If the income is direct deposited (DD) to a bank, please list the bank under the Bank/DD column:

Source	Payee	Amount	How Often	Bank(DD)

P. **TRANSFERS**: Have you or your spouse given away or transferred any money or property to another person within the past thirty (36) months? Yes _____ No _____ If yes, please list all transfers over $1,000.00 below:

Date of Transfer	Person(s) Transferred to	Amount Transferred

Q. PHYSICIAN: Name and address of your attending physician: _____
_____.

Name and address of your spouse's attending physician, if applicable:_____
_____.

R. **LEGAL DOCUMENTS**: Please indicate whether you or your spouse has any of the following estate planning documents:

Legal Document	Name(s)	Date Executed	Location of Original
Last Will and Testament			
Codicil(s)			
Durable Power of Attorney			
Living Will/Health Care Power of Attorney			
Living Trust			
Gift Tax Returns			

Please bring copies of any applicable legal documents above to your appointment.

Were you referred to our office?_____Yes_____No
If so, who made the referral to you?_____

Date this form was completed:_____

Name of person completing this form:_____
Phone Number _____