

COHEN & OALICAN, LLP CLIENT INFORMATION FORM

Today's Date: _____

Name: _____

DOB: ____/____/____ SSN: ____-____-____

Address: _____

Day Phone: _____ Eve. Phone: _____

County of Residence: _____

U.S. Citizen: Yes ___ No ___ If no, citizen of _____

Employer: _____

Retirement Date: _____ Veteran: Yes ___ No ___

Spouse: _____

DOB: ____/____/____ SSN: ____-____-____

Citizen: Yes ___ No ___ If no, citizen of _____

Employer: _____

Retirement Date: _____ Veteran: Yes ___ No ___

If spouse is deceased, date of death: ____/____/____

FAMILY

Date of Marriage: ____/____/____

Children:

First Name	MI	Last Name	Age	Address (include street, town, state and zip code)	Telephone
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Spouse's Name	Names and Ages of Grandchildren				
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First Name	MI	Last Name	Age	Address (include street, town, state and zip code)	Telephone
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Spouse's Name	Names and Ages of Grandchildren				
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First Name	MI	Last Name	Age	Address (include street, town, state and zip code)	Telephone
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Spouse's Name	Names and Ages of Grandchildren				
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First Name	MI	Last Name	Age	Address (include street, town, state and zip code)	Telephone
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Spouse's Name	Names and Ages of Grandchildren				
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Have you or your spouse been married before? yes _____, no _____

If yes, do you or your spouse have any children from this previous marriage? yes _____, no _____

Do you or your spouse have children who have died leaving children? yes _____, no _____

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 _____

Do you and your spouse have a pre-nuptial or post-nuptial agreement? yes _____, no _____

MEDICAL/DISABILITY

Is anyone in your family disabled? yes _____, no _____

If yes, please explain: _____

Is anyone at risk for becoming seriously ill or disabled because of a medical condition or family history? yes _____, no _____

If yes, please explain: _____

Doctor: _____ Spouse's Doctor: _____
Name Address Name Address

Has anyone in your family recently entered a hospital or skilled nursing facility? yes _____, no _____

Name of facility _____ Date of admission _____

Date of discharge _____ Diagnosis _____

HEALTH INSURANCE

Medicare _____
Number Number

Insurance from Employer _____

Medicare Supplement _____

Long-Term Care Insurance _____

Other _____

FINANCIAL

Income Producing Assets:

Bank accounts, Brokerage Accounts, Stocks, Corporate or U.S. Bonds, other

Description & Location of Property	Value	Account No.	In Whose Name?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TOTAL:			_____

Have you or your spouse made any transfers or gifts of \$10,000 or more during the past three years?
yes _____, no _____

Real Estate:

Description of Property	Purchase Date	Purchase Price	Value	In Whose Name?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are any of the above properties not connected to a sewer line?
yes _____, no _____

Do you or your spouse have an interest in any business?
yes _____, no _____

Monthly Income:

	You	Your Spouse	Joint
Social Security	_____	_____	_____
Employment	_____	_____	_____
Pension from _____	_____	_____	_____
IRAs, Annuities, etc. _____	_____	_____	_____
Rents _____	_____	_____	_____
Business Interest _____	_____	_____	_____
Other _____	_____	_____	_____
TOTALS:	_____	_____	_____

Which sources of income have a benefit for a surviving spouse? _____

Life Insurance:

Whose Life?	Company	Face Value	Cash Value	Policy No.	Beneficiary
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Other Property with Designated Beneficiaries

Do you have IRAs, Vested Pension Plan, Annuities, or Other Assets that would pass on your death to a particular designated beneficiary?

Description	Value	Designated Beneficiary
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you or your spouse expect an inheritance? yes _____, no _____

Are you or your spouse the beneficiary of any trust? yes _____, no _____

Liabilities: (mortgages, notes to banks, notes to others, loans on insurance, other)

Description	Balance Due	Monthly Payment	Maturity Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Location of important papers: _____

Monthly Expenses

Health insurance premium _____ Medical Expenses _____

Real estate taxes _____ Homeowner’s insurance premium _____

Condominium Fee _____ Rent _____

Do you pay for heat and utilities? Yes ___ No ___

PERSONAL PROPERTY (Autos, R.V.s, Boats, Antiques, Heirlooms, Jewelry, Collections, etc.)

Description of Property	Value	In Whose Name?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEGAL

	Date Made	Location of Original
Last Will and Testament	_____	_____
Durable Power of Attorney	_____	_____
Living Will/Health Care Proxy	_____	_____
Living Trust	_____	_____

I am the legally appointed guardian of: _____

I am serving as a power of attorney for: _____

I am serving as executor or administrator of an estate: _____

I am involved in a lawsuit: _____

I have lived in a community property state (Arizona, Calif., Idaho, Louisiana, Nevada, New Mexico, Texas, Washington)

Other legal concerns: _____

Please bring copies of the following documents with you to your meeting with the attorney:

1. Will, Codicil, Trust Agreements
2. Real Estate Deeds, Appraisals
3. Admission Agreements to hospitals and health facilities
4. Divorce Decrees, Prenuptial Agreements, Adoption Papers
5. Guardianship documents
6. Living Will, Health Care Declaration or Power of Attorney, Durable Powers of Attorney
7. A list of full names, addresses, telephone numbers of people who have a part in your planning as executors, trustees, beneficiaries of your estate, helpers, and advisors
8. Retirement plans, including any forms designating beneficiaries