GRIMALDI & YEUNG LLP

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Client Questionnaire

Client Information (Person(s) receiving the Bill):

Name: ____________________

Address: ____________________

City: __________ State: ______ ZIP: ______

Phone: Home: __________ Work: __________

Fax: ______ E-Mail: __________

Relationship to Person in Need: __________

Referred by: Name: __________

Address: __________

Person who Needs Assistance (if not client):

Name: ____________________

Address: ____________________

City: __________ State: ______ ZIP: ______

Phone: Home: __________ Work: __________

Fax: ______ E-Mail: __________

Birth Date: __________

Date of Retirement: __________

Occupation: __________

Social Security Number: __________

Union: ( ) Yes, ( ) No Veteran: ( ) Yes, ( ) No

Other Contact Person:

Name: ____________________

Address: ____________________

City: __________ State: ______ ZIP: ______

Phone: Home: __________ Work: __________

Fax: ______ E-Mail: __________

Relationship to Person in Need: __________

Spouse: Married: ( ) Yes, ( ) No

Name: ____________________

Birth Date: __________

Retirement Date: __________

Occupation: __________

Social Security Number: __________

Union: ( ) Yes, ( ) No Veteran: ( ) Yes, ( ) No

Family Description:

Number of Children: ______ Names: ____________________

Number of Grandchildren: ______ Special Comments/Notes: ____________________

____

Real Property Information:

Primary Residence: ( ) Single Family, ( ) Multiple Families ( ) Co-op, ( ) Condominium, ( ) Other: ______

Mortgage Payment: _________ Purchase Price Purchase Date: __________________Market Value: _________________

( ) Rent: Monthly Rent: _________**Second Residence:** ( ) Single Family, ( ) Multiple Family ( ) Co-op, ( ) Condominium,
( ) Other: ____
Mortgage Payment: ____________ Purchase Price: ________________ Market Value: ________________

Life Insurance:

Company	Policy Number	Face Value	Cash Value	Owner	Beneficiary

Income:

	Person in Need	Spouse
Social Security:		
Pension:		
Other:		
Health Insurance:		
Monthly Premium:		

Comments:

Medicare Card ( ) yes ( ) no

Medigap

Company Name:		
Policy Number:		
Premium Amt:		
HMO:		
Standard:		

L.T.C. Insurance Catastrophic

Company:		
Policy Number:		
Coverage:		

Medical Information:

Your Primary Care Physician:

Name: ____________________________________ Telephone:________________________________

Address:____

Health Care Needs that Require Special Attention: ____________________________________
____
____

Your financial advisor/broker:

Name: ____________________________________ Telephone:________________________________

Address:____

Your Accountant/tax preparer

Name: ____________________________________ Telephone:________________________________

Address:____

Financial Accounts:

Bank Name	Type of Account	Account Name	Account Number	Amount	Dates

Stocks/ Investment Accounts:

Company Name	Number of Shares	Account Name	Account Number	Present Value	Date of Purchase

Bonds/ Funds:

Company Name	Maturation Date	Account Name	Account Number	Present Value	Date of Purchase

Other: Retirement Accounts, IRA's, Annuities, T-Bills, or Other Accounts

Company	Account Number	Face Value	Cash Value	Owner	Beneficiary