Please print and fill form out with blue or black ink.

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Client Questionnaire

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

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: Home: _____ Work: _____

Cell: _____

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: _____

Cell: _____

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: _____

Partner/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	Partner/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