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Form Instructions: This data sheet helps us organize your information regarding your family and estate so that we are able to recommend and provide a beneficial estate plan. Please fill out as completely as possible and place X's on inapplicable items and question marks on questions which you don't know the answer. For financial items, it is best to provide as much information as possible. If there is a number you believe might not be precise, please write "estimate" next to the information.

Please email to admin@houstonelderlawyer.com or Fax to: (713) 624-4295

Personal Information		
	You	Your Spouse
Full Legal Name:		
Nickname or Preferred Name:		
Birth Date:		
Date of Death (If applicable):		
Social Security Number:		
Occupation:		
Estimated Annual Income:		
Work Phone Number:		
Fax Number:		
Cell/Home Phone Number(s):		
Email Address:		
Home Address (Include County):		
Where you currently reside (if not at home):		
Referred by:		
Military Service Information: (Branch, Date of Entry & Separation)		
Marital Status & Date and Place of Marriage (If applicable)	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
If you have lived outside Texas during this marriage, please list the states and dates of residence:		
If either of you were previously married, list the dates of prior marriage, name or prior spouse, names of living children from prior marriage(s), and state whether marriage ended by death or divorce:		
Location of Safe Deposit Box:		

Name and Phone of Insurance Agent:	
Name and Phone of Accountant:	
Name and Phone of Financial Planner:	
Existing Estate Planning Documents: (Please List Date Document was Executed)	<input type="checkbox"/> Trust (Type: _____) <input type="checkbox"/> Will <input type="checkbox"/> Financial Power of Attorney <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Directive to Physicians <input type="checkbox"/> HIPAA Authorization <input type="checkbox"/> Declaration of Guardian <input type="checkbox"/> Other: _____
Name and Phone of Current Financial/Medical Power of Attorney:	<input type="checkbox"/> Trust (Type: _____) <input type="checkbox"/> Will <input type="checkbox"/> Financial Power of Attorney <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Directive to Physicians <input type="checkbox"/> HIPAA Authorization <input type="checkbox"/> Declaration of Guardian <input type="checkbox"/> Other: _____

Children

Full Legal Name and Birthdate	Address & Contact Information (If Child Does Not Reside With You)	Other
Name: Birthdate:	Address: Phone: Email:	Child of: <input type="checkbox"/> Joint <input type="checkbox"/> You <input type="checkbox"/> Spouse Occupation: _____ Married: <input type="checkbox"/> Yes <input type="checkbox"/> No Children: <input type="checkbox"/> Yes <input type="checkbox"/> No How many: _____
Name: Birthdate:	Address: Phone: Email:	Child of: <input type="checkbox"/> Joint <input type="checkbox"/> You <input type="checkbox"/> Spouse Occupation: _____ Married: <input type="checkbox"/> Yes <input type="checkbox"/> No Children: <input type="checkbox"/> Yes <input type="checkbox"/> No How many: _____
Name: Birthdate:	Address: Phone: Email:	Child of: <input type="checkbox"/> Joint <input type="checkbox"/> You <input type="checkbox"/> Spouse Occupation: _____ Married: <input type="checkbox"/> Yes <input type="checkbox"/> No Children: <input type="checkbox"/> Yes <input type="checkbox"/> No How many: _____
Name: Birthdate:	Address: Phone: Email:	Child of: <input type="checkbox"/> Joint <input type="checkbox"/> You <input type="checkbox"/> Spouse Occupation: _____ Married: <input type="checkbox"/> Yes <input type="checkbox"/> No Children: <input type="checkbox"/> Yes <input type="checkbox"/> No How many: _____

What is the current health status of you and your spouse? Any specific problems or concerns? Issues with capacity?

You: _____

Spouse: _____

Is there anyone in your family with medical concerns or that requires special needs? Yes No

Please Explain: _____

What would you like us to help you accomplish?

Is there anything else about you or your family or your personal planning goals that you would like us to know?

Do you or your spouse have long term care insurance? You Spouse Both No

Assets

Description <i>(***List Name, Type, and Details of Asset***)</i>	Current Fair Market Value	How Is Title Held?*
Bank Accounts <i>(not IRAs and Retirement Plans):</i>		
Stocks, Bonds, and Mutual Funds <i>(not IRAs and Retirement Plans):</i>		
Closely Held Businesses, Partnerships, Etc.:		
Real Estate:		
Automobiles, Boats, Etc.:		
Other Property:		
Total:		

***Important: If you know if the property is your separate property, your spouse’s separate property, or community property, please so state. If not, state the name(s) which appear on the title, if known, and state whether the property is held with JTWROS (Joint Tenancy With Rights of Survivorship), or who the current beneficiaries are, if known. If property is held in trust, please state the name of the specific trust.**

IRAs, 401(k)s, and Other Retirement Plans

Company/Custodian	Participant	Type of Plan	Current Value	Death Benefit
Total:				

Life Insurance and Annuities

Company	Insured/Owner	Type of Policy/ Details	Beneficiary(s)	Face Amount	Cash Value
Total:					

Monthly Gross Income

Description of Income Source <i>(If annual income, please specify)</i>	Monthly Gross Amount	
	You	Spouse
Wages <i>(please specify employer):</i>		
Pension <i>(please specify pension source):</i>		
Social Security:		
Investments/Dividends <i>(please specify source):</i>		
Rental Profits:		
Other <i>(please specify):</i>		
Total:		

Liabilities

Description of Liability <i>(Please specify details of liability)</i>	Amount
Mortgages:	
Other Liabilities:	
Total:	

Medical Expenses

Expense Type	Details of Expense <i>(type of policy, provider details)</i>	Spent For You or Spouse	Amount of Expense	Daily, Monthly or Annual Expense
Health Insurance <i>(Medicare Supp):</i>				
Health Insurance <i>(Medicare Deduction from Social Security):</i>				
Health Insurance <i>(Private):</i>				
Care Agency/Facility Fees <i>(IL, AL, or SNF):</i>				
Prescription Costs:				
Other:				

Dispositive Plan:**(Describe in general terms how you wish to leave your property at death)**

