

## CONFIDENTIAL CLIENT QUESTIONNAIRE

FIRST NAME	M.I.	LAST NAME	ļ	DATE OF BIRTH			SOCIAL SECURITY #				
spouse's first name	M.I.	LAST NAME		SPOUSE'S DATE OF BIRTH			Social security #				
MAILING ADDRESS	<u> </u>	<u> </u>									
CITY					STATE ZIP CODE						
HOME PHONE					ELL PHONE						
email address					SPOUSE'S EMAIL ADDRESS						
JOB TITLE				SPOUSE'S JOB TITLE							
LAST YEAR, WERE YOU: A FULL TIME STUDENT YES NO					LAST YEAR, WAS YOUR SPOUSE: A FULL TIME STUDENT YES NO						
LEGALLY BLIND YES NO				LEGAL	ALLY & PERMENANTLY DISABLED YES NO ALLY BLIND YES NO						
COVERED BY HEALTH INSURAN CAN ANYONE CLAIM YOU OR	R YOUF		THEIR	TAX RE	TURN	Y HEALTH IN ?	YES	NO	YES	NO	
HAVE YOU OR YOUR SPOUSE BEEN A VICTIM OF IDENTIT HAVE YOU OR YOUR SPOUSE ADOPTED A CHILD?					YES NO						
MARITAL STATUS ON <b>DEC 31</b> : SINGLE M DEPENDENTS					HOW MANY M				ONTHS (0-12) WERE		
NAME (FIRST LAST)	DA	TE OF BIRTH REI		ATIONSHIP		S.S.N.		LIVING WITH YOU?	COVERED BY INSURANCE?		
HOW DID YOU HEAR ABOUT U	Sŝ										
ARE YOU SATISIFED WITH YOUF - WHAT CAN WE DO TO BE	-		-			OAL?			YES	NO	
DO YOU HAVE A?	FINA	NCIAL PLANN	IER		ATTOR	RNEY	WILL	TRUST	N	IONE	
Can we assist you with any	y othi	ER NEEDS TOD	\$YAC								