

## **CONFIDENTIAL CLIENT QUESTIONNAIRE**

FIRST NAME	M.I.	LAST NAME		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, WAS YOUR SPOUSE: A FULL TIME STUDENT YES NO						
LEGALLY BLIND YES NO				legal	ALLY & PERMENANTLY DISABLED YES NO FALLY BLIND YES NO VERED BY HEALTH INSURANCE? YES NO						
CAN ANYONE CLAIM YOU OR YOUR SPOUSE ON THEIR HAVE YOU OR YOUR SPOUSE BEEN A VICTIM OF IDENTIT						?	YES YES	NO NO			
HAVE YOU OR YOUR SPOUSE ADOPTED A CHILD? MARITAL STATUS ON <b>DEC 31</b> : SINGLE M					YES ED WIDOWED DI			NO DIVORCED/	NO DIVORCED/SEPARATED		
DEPENDENTS								HOW MANY MO YOUR D	ONTHS (0-12 EPENDENTS:		
NAME (FIRST LAST)	DA	TE OF BIRTH	REL	ATIONS	SHIP	S.S.N.		LIVING WITH YOU?	COVERED BY INSURANCE?		
HOW DID YOU HEAR ABOUT U	Sš										
ARE YOU SATISIFED WITH YOUF - WHAT CAN WE DO TO BE	-		-			OALŚ			YES	NO	
DO YOU HAVE A?	FINA	NCIAL PLANN	ER		ATTORNEY		WILL	TRUST	Ν	ONE	
Can we assist you with any	( othe	ER NEEDS TOD	?AX5								