

Finger Lakes Attorney PLLC

Christine A. Szpet, Esq.
3678 State Route 5 and 20
Canandaigua, New York 14424
Email: christine@flxatty.com
Office Phone: 585-577-3255
Office Fax: 585-577-3256

Please complete the following questionnaire to the best of your ability. This information is helpful to us so that we may properly plan for you and it will be held in the strictest confidence. We will review this information at our meeting.

1. CLIENT INFORMATION

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Residence Address: _____

Cell: _____ Email: _____

Occupation/Former Occupation: _____

2. CLIENT INFORMATION (IF APPLICABLE)

Legal Name of Significant Other: _____

Preferred Name of Significant Other: _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Relationship with Significant Other: Married Domestic Partnership Civil Union None

Residence Address: _____

Cell: _____ Email: _____

Occupation/Former Occupation: _____

MARITAL INFORMATION (IF APPLICABLE)

Date and Place of Marriage: _____

Have either of you been married previously? Yes No If yes, please provide a copy of divorce decree, as well as any order of spousal support, maintenance or child support that may exist.

Former Spouse Name: _____

Address: _____

Date of Divorce: _____

Former Spouse Name: _____

Address: _____

Date of Divorce: _____

CHILDREN FROM PRESENT RELATIONSHIP

Children of present relationship (living and deceased). Indicate if adopted and give the date adopted and the court granting adoption order. Indicate if deceased and give date of death.

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

CHILDREN FROM PRIOR RELATIONSHIP OF CLIENT #1

Children of a prior relationship to _____:
Indicate if adopted and give the date adopted and the court granting adoption order. Indicate if deceased and give date of death. Use as many copies of page as necessary.

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

CHILDREN FROM PRIOR RELATIONSHIP OF CLIENT #2

Children of a prior relationship to _____:
Indicate if adopted and give the date adopted and the court granting adoption order. Indicate if deceased and give date of death. Use as many copies of page as necessary.

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Name: _____

Preferred Name: _____

Address: _____

Telephone Number(s): _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

GRANDCHILDREN

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Parents' Names: _____

Address Same as Parent(s)? **Yes** **No** If no, please provide address.

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Parents' Names: _____

Address Same as Parent(s)? **Yes** **No** If no, please provide address.

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Parents' Names: _____

Address Same as Parent(s)? **Yes** **No** If no, please provide address.

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Parents' Names: _____

Address Same as Parent(s)? **Yes** **No** If no, please provide address.

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Pronoun(s): He/Him/His She/Her/Hers They/Them/Their _____

Legal Parents' Names: _____

Address Same as Parent(s)? **Yes** **No** If no, please provide address.

OTHER INFORMATION

Please list names and relationships (legal or otherwise) of persons who are dependent on you for support or who are part of your plan, not otherwise identified above.

Do any family members need special attention? Yes No

Is anyone at risk of becoming seriously ill or disabled, either due to a medical condition or family history? Yes No

If yes, provide additional information, including health, physical, mental, financial status, special and/or individual needs:

Do you have or receive any of the following:

Your Social Security? Yes No Monthly Amount: _____

Significant Other’s Social Security? Yes No Monthly Amount: _____

Does anyone in your family receive Supplemental Security Income: Yes No

Does anyone in your family receive Social Security Disability: Yes No

Employer Health Insurance? Yes No If yes, name: _____

Medicare? Yes No If yes, name: _____

Supplemental Insurance? Yes No If yes, name: _____

Long-Term Care Insurance? Yes No If yes, name: _____

Medicaid Benefits? Yes No Veteran’s Benefits? Yes No

DOCUMENTS – Please provide copies of any of the following:

Do you and your significant other have Wills? Yes No

Do you and your significant other have Durable Powers of Attorney? Yes No

Do you and your significant other have Living Wills? Yes No

Do you and your significant other have Health Care Proxies? Yes No

Do you and your significant other have Living Trusts? Yes No

If yes, indicate whether the Living Trust is Revocable or Irrevocable .

BURIAL ARRANGEMENTS

Do you own a burial plot? Yes No If so, what is the location? _____

Do you have an Irrevocable Burial Fund Contract? Yes No If so, please attach a copy.

KEY PEOPLE WORKSHEET FOR CLIENT #1

Executor: **The person who collects all estate assets and distributes them to the beneficiaries under the will or to a trustee in the case of a trust.**

Executor's Name:	
Address:	
Cell Phone Number:	

Alternate Executor's Name:	
Address:	
Cell Phone Number:	

Trustee: **Person or entity who receives all trust assets under the will, administers and distributes the trust in accordance with the terms of the trust.**

Trustee's Name:	
Address:	
Cell Phone Number:	

Alternate Trustee:	
Address:	
Cell Phone Number:	

Guardian: **Person(s) in charge of the care of minor children.**

Guardian and/or Co-Guardian's Name:	
Address:	
Cell Phone Number:	

Alternate Guardian and/or Co-Guardian's Name:	
Address:	
Cell Phone Number:	

Living Will: A written expression of how you feel about the use of “heroic” measures in life-threatening situations. You can revise this document to reflect your personal wishes.

Do you want more information on a Living Will? Yes No

Health Care Proxy: The person who will act as your health care agent and will make all health care decisions for you in the event you are incapacitated and unable to do so.

Agent's Name:	
Address:	
Cell Phone Number:	

Alternate Agent:	
Address:	
Cell Phone Number:	

Power of Attorney: The person who will handle your financial affairs in the event you are incapacitated and unable to do so.

Agent's Name:	
Address:	
Cell Phone Number:	

Alternate Agent:	
Address:	
Cell Phone Number:	

PROFESSIONAL ADVISORS – Name, Company, Address, Phone Number

Financial Advisor: _____

Tax Preparer/Accountant: _____

Insurance Agent: _____

KEY PEOPLE WORKSHEET FOR CLIENT #2

Executor: **The person who collects all estate assets and distributes them to the beneficiaries under the will or to a trustee in the case of a trust.**

Executor's Name:	
Address:	
Cell Phone Number:	

Alternate Executor's Name:	
Address:	
Cell Phone Number:	

Trustee: **Person or entity who receives all trust assets under the will, administers and distributes the trust in accordance with the terms of the trust.**

Trustee's Name:	
Address:	
Cell Phone Number:	

Alternate Trustee:	
Address:	
Cell Phone Number:	

Guardian: **Person(s) in charge of the care of minor children.**

Guardian and/or Co-Guardian's Name:	
Address:	
Cell Phone Number:	

Alternate Guardian and/or Co-Guardian's Name:	
Address:	
Cell Phone Number:	

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Agent's Name:	
Address:	
Cell Phone Number:	

Alternate Agent:	
Address:	
Cell Phone Number:	

Power of Attorney: The person who will handle your financial affairs in the event you are incapacitated and unable to do so.

Agent's Name:	
Address:	
Cell Phone Number:	

Alternate Agent:	
Address:	
Cell Phone Number:	

PROFESSIONAL ADVISORS – Name, Company, Address, Phone Number

Financial Advisor: _____

Tax Preparer/Accountant: _____

Insurance Agent: _____

ASSETS

1. Real Estate

Owner	Physical Address (Street Name, City/Town, State, Zip Code)	Assessed Value	Mortgage Balance	Original Purchase Price
	(Primary)			
	(Secondary)			
	(Other)			
	(Other)			
	(Other)			
Do you receive a veteran's exemption on your primary residence?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you receive a senior citizen's exemption on your primary residence?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are any of the above-referenced properties investment properties?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, are any held in a Limited Liability Company?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please also provide information regarding rental income:				

2. Cash, Bank Accounts and Certificates of Deposit

Owner	Name of Financial Institution	Current Value
Cash		
Checking Accounts		
Savings/Money Market Accounts		
Certificates of Deposit		

6. Annuities, Mortgages and Notes (Debt owed to you or your significant other)

Owner	Description	Beneficiary	Value

7. Tangible Personal Property – List Owner, Location and Value

Home Furnishings: _____

Automobiles/Boats/RVs/Snowmobiles: _____

Jewelry/Furs: _____

Other: _____

Safe Deposit Boxes: List Location of Box, Contents, Location of Key and Estimated Value:

8. Intangible Personal Property – List Owner, Location and Value

Business Interests: List Name, Type (i.e. LLC, Corporation, Partnership or Sole Proprietorships):

Digital Assets: List Owner, Location, Type _____

9. Other Information

GIFTS YOU HAVE MADE IN EXCESS OF \$17,000 / PER PERSON.

List Name, Date, Amount:

Miscellaneous and/or Comments: _____

How did you hear about us? _____

LIABILITIES (Debt owed by you or your significant other)

Description	Name of Debtor	Balance	Current Payment
Mortgages			
HELOC			
Credit Cards			
Auto Loans			
Student Loans			
Business Loans			