



We would like to take this opportunity to welcome you as a new client and to thank you for your business. We look forward to being of service to you, now and in the future.

Please print clearly

Date _____

Name _____ SSN _____

Birthdate _____ E-mail _____

Drivers Lic _____ State _____ Issued date _____ Exp _____

Address _____ City _____

State _____ Zip _____ Occupation _____

Cell Phone _____ Home Phone _____

Spouse _____ SSN _____

Birthdate _____ E-mail spouse _____

Drivers Lic _____ State _____ Issued date _____ Exp _____

Is spouses home address the same as taxpayers? Yes _____ No _____

Spouse Cell Phone _____ Occupation _____

Referred by _____

Preferred Method of Contact _____

Are you a returning client? Yes _____ No _____

*We retain records relating to professional services that we provide so that we are better able to assist you with your professional needs and, in some cases, to comply with professional guidelines. In order to guard your nonpublic personal information, we maintain physical, electronic, and procedural safeguards that comply with our professional standards.

** Provide a copy of Drivers License

Please list dependent information on the back.

A Professional Accountancy Corporation

FAMILY QUESTIONS

Name of Dependents:

First Name	Last Name	Social Security Number								
Birthdate _____	SEX M/F	RELATIONSHIP			DECEASED CHILD	GRAND CHILD	OTHER	STUDENT	INCOME	DISABLED
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

First Name	Last Name	Social Security Number								
Birthdate _____	SEX M/F	RELATIONSHIP			DECEASED CHILD	GRAND CHILD	OTHER	STUDENT	INCOME	DISABLED
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

First Name	Last Name	Social Security Number								
Birthdate _____	SEX M/F	RELATIONSHIP			DECEASED CHILD	GRAND CHILD	OTHER	STUDENT	INCOME	DISABLED
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 1. Do you have wills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a Revocable Living Trust? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any Irrevocable Trusts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any Tax Exempt Trusts (CRT)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a Family Limited Partnership? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have Private Foundation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any other entities? | <input type="checkbox"/> | <input type="checkbox"/> |

If YES, list below. _____
