

New Client Intake Sheet (one per client)

Contact Information

Legal Name: _____

Physical Address: _____

Mailing Address: _____

Telephone: _____ Cell Phone: _____

Email Address: _____

Personal Information

Preferred Name: _____ Pronouns: _____

Date of Birth: _____ Social Security No.: _____

Spouse/Partner Name: _____

Date of Marriage/Domestic Partnership: _____ Place: _____

Emergency Contact: _____ Phone No.: _____

Race/Ethnicity: _____

Religious Preference: _____

Caregiving Agency Preference: _____

Nursing Home Preference: _____

Members of your household:

Name	Relation	Telephone Number

Pets/type/name: _____

Pet Guardian (other than you): _____

Veterinarian: _____ Phone No.: _____

Medical Information

POLST or DNR/Code Status: _____

Hospital Preference: _____

Diagnoses or Surgeries: (use or attach separate sheet if preferred)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications: (use or attach separate sheet if preferred)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: (use or attach separate sheet if preferred)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Physician(s):

Name/Contact Information: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____

Name/Contact Information: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____

Name/Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Name/Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Dentist:

Name/Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Denturist:

Name/Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Pharmacy:

Name/Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Medical Insurance:

Medicare No.: _____ Effective Date: _____
Part D: _____ Policy No.: _____

Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____
Policy No.: _____ Group No.: _____

Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____
Policy No.: _____ Group No.: _____

Estate Planning

Attorney:

Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Power of Attorney(s):

Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Power of Attorney(s):

Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Executor/Personal Representative:

Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Trustee:

Contact Information: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____

Please provide copies of completed documents:

- Power of Attorney (if we are named, we need an original copy)
- Living Will/Health Care Directive
- Last Will and Testament/Gift List
- Trust
- Community Property Agreement
- Cremation Authorization

Funeral/Burial Arrangements:

Company/Contact Information: _____

Telephone No.: _____ Fax No.: _____

Policy No.: _____ Plot No.: _____

Name of Cemetery: _____

- Burial
- Cremation
- Irrevocable Policy
- Other: _____

Information needed for Death Certificate:

Legal Name: _____

City/State of Birth: _____

Mother's Full name (Maiden): _____

Father Name: _____

Occupation (if retired, last occupation): _____

Armed Forces: YES _____ NO _____ *Please provide DD214 or Separation documents*

Smoke in last 15 years: YES _____ NO _____

Marital Status: _____ Education: _____

Life Insurance or other Insurance:

Contact Information: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____

Policy No.: _____ Group No.: _____

Beneficiary(s): _____

Contact Information: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____

Policy No.: _____ Group No.: _____

Beneficiary(s): _____

Long Term Care Insurance:

Contact Information: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Policy No.: _____

Beneficiaries listed in your WILL/Trust/TOD Accounts:

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Emergency Contacts/Family Members/Friends:

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

Name/Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Cell: _____

Email: _____ Other: _____

*******DO NOT CONTACT OR PROVIDE ANY INFORMATION*******

Name/Relation: _____

Name/Relation: _____

Income and Assets

Sources of Income and Current Amount:

- Social Security _____
- WA State Retirement _____
- Civil Service _____
- Veteran Benefits (File No.) _____
- Retirement _____
- Pension _____
- Rental Income _____
- Stocks _____
- Other _____

CPA:

Name/Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone No.: _____ Cell: _____
Email: _____ Other: _____

Checking/Savings/Money Market/CD: (use or attach separate sheet if preferred)

Branch/Location: _____

Account No.: _____ Type: _____

Does account have a Joint Signer/TOD/POD (if yes, who): _____

Checking/Savings/Money Market/CD:

Branch/Location: _____

Account No.: _____ Type: _____

Does account have Joint Signer/TOD/POD (if yes, who): _____

Checking/Savings/Money Market/CD:

Branch/Location: _____

Account No.: _____ Type: _____

Does account have Joint Signer/TOD/POD (if yes, who): _____

Safe Deposit Box:

Branch/Location: _____

Box No.: _____ Key Location: _____

Does account have Joint Signer (if yes, who): _____

Vehicles/Boats/Motorcycles/RV:

Make/Model/Year: _____

VIN: _____ Title Location: _____

Make/Model/Year: _____

VIN: _____ Title Location: _____

Make/Model/Year: _____

VIN: _____ Title Location: _____

Make/Model/Year: _____

VIN: _____ Title Location: _____

Firearms: (use or attach separate sheet if preferred)

Make/Model: _____

Serial No.: _____ Location: _____

Make/Model: _____

Serial No.: _____ Location: _____

Make/Model: _____

Serial No.: _____ Location: _____

Real Estate: (use or attach separate sheet if preferred)

Address: _____

Legal Description: _____

Parcel No.: _____ County: _____

Mortgage: _____

Address: _____

Legal Description: _____

Parcel No.: _____ County: _____

Mortgage: _____

Address: _____
Legal Description: _____
Parcel No.: _____ County: _____
Mortgage: _____

Address: _____
Legal Description: _____
Parcel No.: _____ County: _____
Mortgage: _____

Investments:

Branch/Location: _____

Account No.: _____ Type: _____
Does account have TOD/POD (if yes, who): _____

Branch/Location: _____

Account No.: _____ Type: _____
Does account have TOD/POD (if yes, who): _____

Branch/Location: _____

Account No.: _____ Type: _____
Does account have TOD/POD (if yes, who): _____

Branch/Location: _____

Account No.: _____ Type: _____
Does account have TOD/POD (if yes, who): _____

Branch/Location: _____

Account No.: _____ Type: _____
Does account have TOD/POD (if yes, who): _____

Other significant information:

Check list for your client file

- ❑ Completed intake sheet (one per client)
- ❑ Legal documents (see page 4 for list)
- ❑ Signed service agreement
- ❑ Copy of current Driver's License or ID or Military ID
- ❑ Copy of Medicare Card
- ❑ Copy of Insurance Cards
- ❑ Copy of POLST (if you have completed one)
- ❑ Copy of Funeral/Burial policy (if you have completed)

Please call the office to set up the in-person client meeting once you have completed your intake sheet and have copies of your completed legal documents.

If you do not have access to a copy machine, we can make copies of the items requested above during the meeting.

Thank you for entrusting us with your case management, bookkeeping, and estate planning needs!