Accounting Professionals
Of West GA, Inc.

New Client Intake Form

Client Information	
Client Contact(s)	
Client Name(s)	
Address Line 1	
Address Line 2	
City, County/State	
Primary Phone	
Alternate Phone	
Email	

Services Interested In *(please check all that apply)*

Tax Services *(please provide DOB & SS Cards for all dependents)*

Individual Tax Return ❑ Corporate Tax Return ❑

DEPENDENT INFORMATION		
Name	**DOB**	**Social Security Number**

Accounting / Bookkeeping Services

Monthly ❑ Quarterly ❑ Yearly ❑

Payroll Services

Payroll Preparation ❑ Payroll Tax Filing ❑

How did you hear about us?	
Referral Source	
Referral Name *(if referred by an individual)*	