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**CLIENT INFORMATION WORKSHEET**

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**PART I - PERSONAL DATA**

**NAME of DECLARANT:** \_\_\_\_\_

**Alias Names (if any):** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Place of Birth:** \_\_\_\_\_

**Driver's License Number:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Is Declarant a U.S. citizen? Yes: \_\_\_\_\_ No: \_\_\_\_\_**

**If naturalized U.S. citizen, Date and Place of Naturalization:** \_\_\_\_\_

*I wish to obtain and execute the following documents:*

- Part II: Last Will and Testament**
- Part III: Durable Power of Attorney**
- Part IV: Medical Power of Attorney**
- Part V: HIPPA Release**
- Part VI: Directive to the Physician**

*Please complete the attached information worksheet for each of the documents you are requesting.*

**PLEASE USE FULL LEGAL NAMES.**

**PART II - WILL**

**CHILDREN'S INFORMATION:**

<b>Name</b>	<b>Living?</b>	<b>Age</b>	<b>Birthdate</b>	<b>Married?</b>	<b>City/State of Residence</b>
_____	Yes/No	_____	_____	Yes/No	_____
_____	Yes/No	_____	_____	Yes/No	_____
_____	Yes/No	_____	_____	Yes/No	_____
_____	Yes/No	_____	_____	Yes/No	_____
_____	Yes/No	_____	_____	Yes/No	_____
_____	Yes/No	_____	_____	Yes/No	_____

For each child, state the name of the child's other parent if not your present spouse. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**OTHER DEPENDENTS, IF ANY:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Residence: \_\_\_\_\_  
 \_\_\_\_\_

**GRANDCHILDREN'S INFORMATION, IF ANY:**

<b>Name:</b>	<b>Age:</b>	<b>Birthdate:</b>	<b>Names of parents:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list the names of your parents, brothers, and sisters if so, list their city and state of residence.

<b>Name:</b>	<b>Relationship:</b>	<b>Living?</b>	<b>Residence:</b>
_____	_____	Yes/No	_____
_____	_____	Yes/No	_____
_____	_____	Yes/No	_____
_____	_____	Yes/No	_____

List, as well, the same information for your spouse's parents and siblings.

Name:	Relationship:	Living?	Residence:
_____	_____	Yes/No	_____
_____	_____	Yes/No	_____
_____	_____	Yes/No	_____
_____	_____	Yes/No	_____

**Please provide the following information regarding any former marriages, if any:**

Name of former spouse: \_\_\_\_\_  
Living? \_\_\_\_\_  
Date of Death and/or Divorce: \_\_\_\_\_

**Please provide the following information regarding your spouse's former marriages, if any:**

Name of former spouse: \_\_\_\_\_  
Living? \_\_\_\_\_  
Date of Death and/or Divorce: \_\_\_\_\_

Do you presently have a Will? Yes: \_\_\_ No: \_\_\_ If so, what is the date on the Will? \_\_\_\_\_  
Was it signed in Texas? Yes: \_\_\_ No: \_\_\_ If not, where? \_\_\_\_\_

Amended Will or Codicil? Yes: \_\_\_ No: \_\_\_ Date: \_\_\_\_\_

Spouse presently has a Will? Yes: \_\_\_ No: \_\_\_ If so, what is the date on the Will? \_\_\_\_\_  
Was it signed in Texas? Yes: \_\_\_ No: \_\_\_ If not, where? \_\_\_\_\_

Amended Will or Codicil? Yes: \_\_\_ No: \_\_\_ Date: \_\_\_\_\_

Are you a beneficiary, trustee (singly or jointly), or creator of a trust?  
Yes: \_\_\_ No: \_\_\_ If so, what is the name and date of the trust? \_\_\_\_\_

Is your spouse a beneficiary, trustee (singly or jointly), or creator of a trust?  
Yes: \_\_\_ No: \_\_\_ If so, what is the name and date of the trust? \_\_\_\_\_

**PART II-a**  
**YOUR DISPOSITIVE PLAN**

Describe in general terms how you wish to distribute your property under your will: \_\_\_\_\_

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**PART II-b**  
**SPOUSE'S DISPOSITIVE PLAN**

Describe in general terms how you wish to distribute your property under your will: \_\_\_\_\_

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**Describe in SPECIFIC terms how you wish to distribute any particular property under your will, (i.e. gold watch from my grandfather to my son, John):** \_\_\_\_\_

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If your children are beneficiaries of your property, do you want the property to be distributed to your children outright or in trust until a certain date?

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If your grandchildren are beneficiaries of your property, do you want the property to be distributed to your grandchildren outright or in trust until a certain date?

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**Do you wish to include:**

**A NO CONTEST CLAUSE? YES or NO**

**FUNERAL PREFERENCES OR ARRANGEMENTS? YES or NO, if Yes, please include details.**

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**PART II-c - YOUR DESIGNEES**

**EXECUTOR** (*i.e., the person who will be responsible for probating your will, filing the estate tax return, if necessary, and distributing assets to the beneficiaries*)

Name of Executor: \_\_\_\_\_  
1st Alternate Executor: \_\_\_\_\_  
2nd Alternate Executor: \_\_\_\_\_  
3rd Alternate Executor: \_\_\_\_\_

**Complete the following section if your spouse is requesting different persons be named:**

Name of Executor: \_\_\_\_\_  
1st Alternate Executor: \_\_\_\_\_  
2nd Alternate Executor: \_\_\_\_\_  
3rd Alternate Executor: \_\_\_\_\_

**TRUSTEE** (*i.e., the person who will be responsible for the long-term management of property for the surviving spouse, children or other beneficiaries*)

Name of Trustee: \_\_\_\_\_  
1st Alternate Trustee: \_\_\_\_\_  
2nd Alternate Trustee: \_\_\_\_\_  
3rd Alternate Trustee: \_\_\_\_\_

**Complete the following section if your spouse is requesting different persons be named:**

Name of Trustee: \_\_\_\_\_  
1st Alternate Trustee: \_\_\_\_\_  
2nd Alternate Trustee: \_\_\_\_\_  
3rd Alternate Trustee: \_\_\_\_\_

**GUARDIAN OF MINOR CHILDREN, if applicable.** (i.e. the person who will take physical care of your minor children should both parents die)

Name of Guardian: \_\_\_\_\_  
1st Alternate Guardian: \_\_\_\_\_  
2nd Alternate Guardian: \_\_\_\_\_  
3rd Alternate Guardian: \_\_\_\_\_

**Complete the following section if your spouse is requesting different persons be named:**

Name of Guardian: \_\_\_\_\_  
1st Alternate Guardian: \_\_\_\_\_  
2nd Alternate Guardian: \_\_\_\_\_  
3rd Alternate Guardian: \_\_\_\_\_

### **PART III - DURABLE POWER OF ATTORNEY:**

*(Complete this information for yourself and your spouse; Make copies of these pages if necessary.)*

**NAME of PERSONAL REPRESENTATIVE, for Durable Power of Attorney::** \_\_\_\_\_  
\_\_\_\_\_

**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_  
**Zip Code:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_  
**Cell #:** \_\_\_\_\_  
**Work #:** \_\_\_\_\_  
**Fax #:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_  
**Relationship to Declarant, if any:** \_\_\_\_\_

**NAME of ALTERNATE REPRESENTATIVE:** \_\_\_\_\_  
\_\_\_\_\_

**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_  
**Zip Code:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_  
**Cell #:** \_\_\_\_\_  
**Work #:** \_\_\_\_\_  
**Fax #:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_  
**Relationship to Declarant, if any:** \_\_\_\_\_

**PART IV: MEDICAL POWER OF ATTORNEY**

*Complete this information for the person(s) to be named in the medical power of attorney with authority to act on behalf of the Declarant. If the Personal Representative and First Alternate are the same as set out above, you may complete on the information for the Second Alternate.*

**NAME of PERSONAL REPRESENTATIVE, for Durable Power of Attorney::** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Cell #:** \_\_\_\_\_

**Work #:** \_\_\_\_\_

**Fax #:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Relationship to Declarant, if any:** \_\_\_\_\_

**NAME of FIRST ALTERNATE REPRESENTATIVE:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Home #:** \_\_\_\_\_

\_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Work #:** \_\_\_\_\_

**Fax #:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Relationship to Declarant, if any:** \_\_\_\_\_

**NAME of SECOND ALTERNATE REPRESENTATIVE:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Home #:** \_\_\_\_\_

\_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Work #:** \_\_\_\_\_

**Fax #:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Relationship to Declarant, if any:** \_\_\_\_\_



**PART V - HIPAA RELEASE**

*Please provide the following information for each and every person that the Declarant is authorizing to have access to their medical condition should they be hospitalized, become incapacitated or need to act on behalf of the Declarant. Repeat for each person to be named.*

**NAME:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_  
**Zip Code:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Work #:** \_\_\_\_\_  
**Fax #:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_  
**Relationship to Declarant, if any:** \_\_\_\_\_

**NAME:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_  
**Zip Code:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_  
**Cell #:** \_\_\_\_\_  
**Work #:** \_\_\_\_\_  
**Fax #:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_  
**Relationship to Declarant, if any:** \_\_\_\_\_

**NAME:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_  
**Zip Code:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_  
**Cell #:** \_\_\_\_\_  
**Work #:** \_\_\_\_\_  
**Fax #:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_  
**Relationship to Declarant, if any:** \_\_\_\_\_

## PART V - DIRECTIVE TO THE PHYSICIAN

*Please provide the following information for instructions you wish your physician(s) to follow if you are unable to make these decisions yourself.*

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

**CHOOSE ONE:**

\_\_\_\_\_ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible;

**OR**

\_\_\_\_\_ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

**AND**

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

\_\_\_\_\_ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

**OR**

\_\_\_\_\_ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

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