

Robert W. Carlson, Attorney at Law, P.C.
(a Florida Professional Corporation)
Admitted to Practice Law in Florida and Massachusetts
192 Orchard Pass Avenue, Suite 516
Ponte Vedra, Florida 32081
Office: (904) 944-1704
Cell Phone: (781) 239-3500
Facsimile: (904) 515-2557
Email: rcarlson@robertcarlsonlaw.com

Confidential

Estate Planning Intake Form

Dear Client,

Thank you in advance for placing your trust in my Firm and for allowing me to assist in your estate planning needs. Please complete the attached confidential estate planning intake form as it applies to you. Please note that all information you share with my firm will remain confidential and is a privileged attorney/client communication.

If you have questions or concerns, please do not hesitate to contact me at any time.

Warm Regards,

Robert W. Carlson

Robert W. Carlson, Attorney at Law, P.C.

(A Florida Professional Corporation)

192 Orchard Pass Avenue, Suite 518

Ponte Vedra, Florida, 32081- 4311

Direct Line / Cell Phone: (904) 944-1704

Facsimile: (904) 515-2557

Email: rcarlson@robertcarlsonlaw.com

Web Site: www.robertcarlsonlaw.com

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Confidential Estate Planning Intake Form

Personal and Confidential

Client Information

Last name:		First Name:		Middle:	
Mr/Mrs/Dr/Other:		Other/Former name(s):			
Date of Birth:			Social Security No:		
Street Address or PO Box:					
City:		State:	Zip:	County of Residence:	
Home Phone:				Cell Phone:	
Email Address:					
Employer :			Occupation/Position:		
Annual Salary :			Business Phone:		

Other Monthly Income:

Pension:	\$:	Source:
Rental:	\$:	Source:
Disability:	\$:	Source:
Investment:	\$:	Source:
Pension:	\$:	Source:

Are you making payment pursuant to a divorce or property settlement?	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	N/A <input type="checkbox"/>	
Have you ever had a will or a trust?	Will : Yes <input type="checkbox"/>	No <input type="checkbox"/>	Trust : Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you marked YES under TRUST, Please provide the full legal name of trust and date of creation:				
Name:		Date:		
What is your current health status?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	
Any Specific health concerns/issues?				
Are you a US Citizen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are you a disabled Veteran?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Who referred you to Me?				

Spouse/Partner Information (If Applicable)

Last name:		First Name:		Middle:
Mr/Mrs/Dr/Other:		Other/Former name(s):		
Date of Birth:		Social Security No:		
Street Address or PO Box:				
City:	State:	Zip:	County of Residence:	
Home Phone:			Cell Phone:	
Email Address:				
Employer :		Occupation/Position:		
Annual Salary :		Business Phone:		

Other Monthly Income:

Pension:	\$:	Source:
Rental:	\$:	Source:
Disability:	\$:	Source:
Investment:	\$:	Source:
Pension:	\$:	Source:

Do you have a prenuptial agreement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are you making payments pursuant to a divorce or property settlement?	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	N/A <input type="checkbox"/>	
Have you ever had a will or Trust?	Will Yes <input type="checkbox"/>	No <input type="checkbox"/>	Trust Yes <input type="checkbox"/>	No <input type="checkbox"/>
What is your current health status?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	
Any Specific health concerns/issues?				
Are you a US Citizen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are you a disabled Veteran?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

To assist with creating your estate plan, please answer the following questions.

Please note there are no right or wrong answers – only your answers:

Identify any of the following issues that are important to you with an “X”

	Client	Spouse/Partner
Minimize Gift and Estate Taxes	<input type="checkbox"/>	<input type="checkbox"/>
Provide for Disabled Descendants	<input type="checkbox"/>	<input type="checkbox"/>
Eliminate Probate or Guardianship	<input type="checkbox"/>	<input type="checkbox"/>
Protect Children/Grandchildren from Divorce and Creditors	<input type="checkbox"/>	<input type="checkbox"/>
Provide for Children	<input type="checkbox"/>	<input type="checkbox"/>
Protect children from immature spending Habits	<input type="checkbox"/>	<input type="checkbox"/>
Provide for grand children	<input type="checkbox"/>	<input type="checkbox"/>
Protect Children’s inheritance in the Event of Subsequent Remarriage by the Survivor	<input type="checkbox"/>	<input type="checkbox"/>
Plan for a Disability	<input type="checkbox"/>	<input type="checkbox"/>
Pass Values and Responsibility to Family Members	<input type="checkbox"/>	<input type="checkbox"/>

What is your goal in meeting with me?

What is your most important financial goal?

What do you see as the major threat to your personal goals?

Do you have any family dynamics that may affect your estate planning?

Are you or your spouse taking a trip out of the state or out of the country in the next 12 months?

Yes No Maybe

Family Information

Previous Marriage(s) by Client (include previous spouse's Names, Date of Marriage, or Date of Death)

Previous Marriage(s) by Spouse/Partner (include Previous Spouse's Names, Date of Marriage, or Date of Death)

Living Children (On the "Child of:" line indicate if child is(J)) Joint, (H) Husband's, (W) Wife's, or (P) Partner's Child.)

1. Full Name: _____ DOB: _____ Child of: _____ Adopted(Y/N): _____

Gender: _____ Current Address: _____

2. Full Name: _____ DOB: _____ Child of: _____ Adopted(Y/N): _____

Gender: _____ Current Address: _____

3. Full Name: _____ DOB: _____ Child of: _____ Adopted(Y/N): _____

Gender: _____ Current Address: _____

4. Full Name: _____ DOB: _____ Child of: _____ Adopted(Y/N): _____

Gender: _____ Current Address: _____

5. Full Name: _____ DOB: _____ Child of: _____ Adopted(Y/N): _____

Gender: _____ Current Address: _____

Deceased Children (On the "Child of" line indicate if Child is (J) Joint, (H) Husband's, (W) Wife's, or (P) Partner's Child.)

Name	Birth Date	Date of Death	Male/Female	Child of
------	------------	---------------	-------------	----------

_____	_____	_____	_____	_____
-------	-------	-------	-------	-------

_____	_____	_____	_____	_____
-------	-------	-------	-------	-------

Are you or your Spouse/Partner pregnant or anticipating becoming pregnant in the near future? Yes No

Have you or your Spouse/Partner ever had a child born outside of marriage? Yes No

Have you or your Spouse/Partner ever had a child given up for adoption or for which parental rights have been terminated? Yes No

Family Information (Continued)

Grandchildren

<u>Name</u>	<u>Birth Date</u>	<u>Parent's Names</u>	<u>M/F</u>	<u>Adopted(Y/N)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Client's Parents

<u>Name</u>	<u>Relation</u>	<u>Select One</u>	<u>Name</u>	<u>Relation</u>	<u>Select One</u>
_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>
_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>
_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>
_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>

Spouse/Partner's Parents

Client's Siblings

<u>Name</u>	<u>Relation</u>	<u>Select One</u>	<u>Name</u>	<u>Relation</u>	<u>Select One</u>
_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>
_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>
_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>
_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	_____	_____	Living <input type="checkbox"/> Deceased <input type="checkbox"/>

Spouse/Partner's Siblings

Have any of the named people ever had a child given up for adoption or for which parental rights have been terminated? Yes No

Does anyone in your immediate family have any special educational, medical, or physical needs? Yes No

If Yes, please explain:

Other than with your minor children (if applicable), do you foresee a time when someone may be dependent on you? Yes No

If Yes, please explain:

Real Property

Include your personal residence(s), investment property, vacation homes (excluding time shares), vacant land, mineral interests, etc. If you have a copy of your legal description or deed, please attach a copy to this form.

1. Type (residence, rental, vacant land etc.) _____

Address & County: _____

Owner(s): _____

Current Value: \$ _____ Outstanding Mortgage? Yes No

2. Type (residence, rental, vacant land etc.) _____

Address & County: _____

Owner(s): _____

Current Value: \$ _____ Outstanding Mortgage? Yes No

3. Type (residence, rental, vacant land etc.) _____

Address & County: _____

Owner(s): _____

Current Value: \$ _____ Outstanding Mortgage? Yes No

4. Type (residence, rental, vacant land etc.) _____

Address & County: _____

Owner(s): _____

Current Value: \$ _____ Outstanding Mortgage? Yes No

5. Type (residence, rental, vacant land etc.)
Address & County:
Owner(s):
Current Value: \$ Outstanding Mortgage? Yes No

Bank Accounts and Investment Accounts

Please do not list retirement account in this section such as: IRAs, 401Ks, Roth IRAs, SEPs, etc.

1. Name of Bank/Institution:
Account type: Account Number:
Name on Account: Balance: \$
Advisor Name:
2. Name of Bank/Institution :
Account type : Account Number:
Name on Account : Balance : \$
Advisor Name :
3. Name of Bank/Institution :
Account type : Account Number:
Name on Account : Balance : \$
Advisor Name :
4. Name of Bank/Institution :
Account type : Account Number:
Name on Account : Balance : \$
Advisor Name :
5. Name of Bank/Institution :
Account type : Account Number:
Name on Account : Balance : \$
Advisor Name :
6. Name of Bank/Institution :
Account type : Account Number:
Name on Account : Balance : \$
Advisor Name :

Do you have any Safe Deposit Boxes? Yes No If yes, what is the Box Number?

Name of Institution: Name(s) on Box:

Retirements Accounts

Please list your IRAs, 401Ks, SEPs, Profit Sharing, Thrift Savings, etc.

1. Name of Institution: _____ Name(s) on Accounts: _____
Account type: _____ Account Number: _____ Balance: \$ _____
Current Beneficiaries: _____ Advisor: _____
2. Name of Institution: _____ Name(s) on Accounts: _____
Account type: _____ Account Number: _____ Balance: \$ _____
Current Beneficiaries: _____ Advisor: _____
3. Name of Institution: _____ Name(s) on Accounts: _____
Account type: _____ Account Number: _____ Balance: \$ _____
Current Beneficiaries: _____ Advisor: _____
4. Name of Institution: _____ Name(s) on Accounts: _____
Account type: _____ Account Number: _____ Balance: \$ _____
Current Beneficiaries: _____ Advisor: _____
5. Name of Institution: _____ Name(s) on Accounts: _____
Account type: _____ Account Number: _____ Balance: \$ _____
Current Beneficiaries: _____ Advisor: _____
6. Name of Institution: _____ Name(s) on Accounts: _____
Account type: _____ Account Number: _____ Balance: \$ _____
Current Beneficiaries: _____ Advisor: _____
7. Name of Institution: _____ Name(s) on Accounts: _____
Account type: _____ Account Number: _____ Balance: \$ _____
Current Beneficiaries: _____ Advisor: _____

Life Insurance Policies

1. Life Insurance Company : _____ Policy Number: _____
Owner of Policy : _____ Insured: _____
Current Beneficiaries : _____ Death Benefit: _____
Type of Policy : _____ Agent Name: _____
2. Life Insurance Company : _____ Policy Number: _____
Owner of Policy : _____ Insured: _____
Current Beneficiaries : _____ Death Benefit: _____
Type of Policy : _____ Agent Name: _____
3. Life Insurance Company : _____ Policy Number: _____
Owner of Policy : _____ Insured: _____
Current Beneficiaries : _____ Death Benefit: _____
Type of Policy : _____ Agent Name: _____
4. Life Insurance Company : _____ Policy Number: _____
Owner of Policy : _____ Insured: _____
Current Beneficiaries : _____ Death Benefit: _____
Type of Policy : _____ Agent Name: _____
5. Life Insurance Company : _____ Policy Number: _____
Owner of Policy : _____ Insured: _____
Current Beneficiaries : _____ Death Benefit: _____
Type of Policy : _____ Agent Name: _____

Disability Insurance:

Do you currently have disability insurance? _____ Yes No

Insurance Provider : _____ Policy No: _____

Information for Business Owners

Do you own a business? (if no please proceed to the next section) _____ Yes No

Name of Business : _____

Address of Business : _____

Phone Number : _____ Tax identification Number of Business : _____

How is your business currently being taxed? C-Corp S-Corp Partnership Sole Proprietorship

List the Owners/Members/Shareholders of your business and the ownership percentage for each on the lines below:

<u>Owner/Member/Shareholder</u>	<u>Percentage</u>	<u>Units/Shares</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate if your business already has in place one of the following:

Operating Agreement Corporate Minutes Bylaws Buy-Sell Agreement

Other: _____

Do you anticipate the business continuing operations following your retirement, incapacitation or Death? Yes No

Has your business been valuated? Yes No

Current Value of your Business? \$ _____

Do you have whole or part ownership in another/other Business Yes No

Other Information or Businesses: _____

Please use a separate sheet for additional businesses

Advisors

Financial Planner:

Company : _____

Address: _____

Phone: _____

E-mail: _____

Client(s) authorize(s) me to contact their financial planner? Yes No

Accountant:

Company : _____

Address: _____

Phone: _____

E-mail: _____

Client(s) authorize(s) me to contact their Accountant? Yes No

Life Insurance Agent:

Company : _____

Address: _____

Phone: _____

E-mail: _____

Client(s) authorize(s) me to contact their Life Insurance Agent Yes No

Attorney:

Company : _____

Address: _____

Phone: _____

E-mail: _____

Client(s) authorize(s) me to contact their personal Attorney Yes No

Funeral Home:

Company : _____

Address: _____

Phone: _____

E-mail: _____

Client(s) authorize(s) me to contact their Funeral Home Yes No

Trust Information

Preferred Name of Trust: _____

Successor Trustee

The Successor trustee takes over control of your trust after you or your original trustee can no longer serve as trustee. When your estate plan involves a revocable trust, you and/or Your Spouse/Partner usually serve as the initial Trustees. The Successor Trustee can be an individual, more than one individual, or a corporate entity (such as a bank or a trust company.)

First Choice: _____

Second Choice: _____

Third Choice: _____

Special Instructions: _____

Guardian for Minor Children (If Applicable)

Please list the individual(s) who should be responsible for the care and control of your children in the event you are incapacitated or deceased.

Client' s Choice

Spouse/Partner's Choice (If Applicable)

First Choice: _____

Second Choice: _____

Third Choice: _____

Special Instructions: _____

Personal Representative

Your Personal Representative will liquidate and administer your probate estate if necessary, your Personal Representative may be the same person or entity that you have named as your Successor Trustee.

Client' s Choice

Spouse/Partner's Choice (If Applicable)

First Choice: _____

Second Choice: _____

Third Choice: _____

Durable Power of Attorney

A Durable Power of Attorney is an individual who serves as an Attorney-in-Fact and is authorized to act on your behalf in a limited or general financial capacity. Your Attorney-in-Fact's powers may be effective immediately or they may become effective only upon your incapacitation.

Client's Choice

Spouse/Partner's Choice (If Applicable)

First Choice: _____

Address: _____

Telephone No: _____

Second Choice: _____

Address: _____

Telephone No: _____

Third Choice: _____

Address: _____

Telephone No: _____

Should your Attorney-in Fact have the right to immediately exercise these Powers?: Yes No

Special Instructions: _____

Healthcare Power of Attorney

A Healthcare Power of Attorney is an individual you select as an agent to make decisions in regard to your medical care should you become incapacitated.

Client's Choice

Spouse/Partner's Choice (If Applicable)

First Choice: _____

Address: _____

Telephone No: _____

Second Choice: _____

Address: _____

Telephone No: _____

Third Choice: _____

Address: _____

Telephone No: _____

Special Instructions: _____

If you are at the end of your life or in a terminal condition, do you wish to be on life support? Yes No

Do you wish to be buried or cremated? _____ Buried Cremated

Does your spouse wish to be buried or cremated? _____ Buried Cremated

Do you want to be an organ donor? Client: Yes No Spouse: Yes No

HIPAA Agent

The individual(s) you appoint as your HIPAA Agent will immediately have full access to any and all of your medical records. Please list the individuals to be named as Authorized Recipients under the Health Insurance Portability and Accountability Act (HIPAA).

Client' s Choice

Agent Name: _____

Address: _____

Agent Name: _____

Address: _____

Agent Name: _____

Address: _____

Agent Name: _____

Address: _____

Agent Name: _____

Address: _____

Agent Name: _____

Address: _____

Spouse/Partner's Choice (If Applicable)

Telephone No: _____

Telephone No: _____

Telephone No: _____

Telephone No: _____

Telephone No: _____

Telephone No: _____

