DISMUKE, WATERS & SWEET
(A Professional Corporation)
ATTORNEYS AND COUNSELORS AT LAW

ARLINGTON OFFICE
2000 EAST LAMAR BLVD., SUITE 500, ARLINGTON, TX 76006
PH: (817) 277-2077 METRO: (817) 261-3508 FAX: (817) 265-7264

SOUTHLAKE OFFICE
1256 MAIN STREET, SUITE 219, SOUTHLAKE, TX 76092
PH: (817) 749-0317 ALT.: (817) 749-0315 FAX: (817) 749-0318
www.dws-law.com

ESTATE PLANNING QUESTIONNAIRE

I. GENERAL INFORMATION

Marital Status: □ Married □ Unmarried □ Unmarried, with long-term partner (domestic partner) □ Widow □ Widower

Are you Registered Domestic Partners? □ Yes □ No □ Don't Know

CLIENT NAME INFORMATION

First Name: ________________ Middle: _________________ Last: ________________________

Nickname (if any): _________________ Alias Name (if any: ____________________________

Gender: □ Male □ Female SS#: _____________________ DOB: ________________

U.S. Citizen? □ Yes □ No

If No, specify citizenship: ____

Health: □ Excellent □ Reasonably good □ Poor □ Serious Adverse Condition

CLIENT SPOUSE/PARTNER INFORMATION

First Name: ________________ Middle: _________________ Last: ________________________

Nickname (if any): _________________ Alias Name (if any: ____________________________

Gender: □ Male □ Female SS#: _____________________ DOB: ________________

U.S. Citizen? □ Yes □ No

If No, specify citizenship: ____

Health: □ Excellent □ Reasonably good □ Poor □ Serious Adverse Condition

CLIENT CONTACT INFORMATION

	Client	Spouse/Partner
Home Phone		
Home Fax		
Home Address (include county)		
Personal Email		
Cell Phone		
Business Phone		
Business Fax		
Business Email		
Business Address		

Referral Information

Who referred you to Dismuke, Waters & Sweet, P.C.?

Name	Address	City	State	Zip

II. CHILDREN (if applicable)

	Name, Address and Telephone Number	**Living**	**Gender**	**Date of Birth**	**Child of Both**	**Child of Client only**	**Child of spouse only If so, which spouse?**
Child 1 Name Address Phone		Y / N	M/F		Y / N	Y / N	Y / N H/W
Child 2 Name Address Phone		Y / N	M/F		Y / N	Y / N	Y / N H/W
Child 3 Name Address Phone		Y / N	M/F		Y / N	Y / N	Y / N H/W
Child 4 Name Address Phone		Y / N	M/F		Y / N	Y / N	Y / N H/W
Child 5 Name Address Phone		Y / N	M/F		Y / N	Y / N	Y / N H/W

GUARDIAN(S) FOR MINOR OR DISABLED CHILDREN (if applicable):

Initial Guardians

Name	**Address**

Successor Guardians

Name	**Address**

III. CLIENT'S RESIDUAL GIFTS (after specific gifts, above)

Spouse/Partner

Want to provide primarily for your Spouse/Partner (and then secondarily for children/descendants, if any)? □ Yes □ No

Children/Descendants

Do you wish to treat children equally? □ Yes □ No

Do you wish to treat grandchildren equally? □ Yes □ No

Other Beneficiaries

Specify gift to other beneficiary(ies):

____

____

IV. EXECUTOR (for Wills)

CLIENT'S EXECUTOR

Initial Executor Under Client's Will

Name
Check if Spouse/Partner is first choice □

Successor Executor Under Client's Will (serve at death/disability of Initial Executor)

Name

SPOUSE/PARTNER'S EXECUTOR

Initial Executor Under Spouse/Partner's Will

Name
Check if Spouse/Partner is first choice □

Successor Executor Under Spouse/Partner's Will (serve at death/disability of Initial Executor)

Name

V. TRUSTEES (if applicable)

CLIENT'S TRUSTEES

Initial Trustee for Client (applicable for trusts)

Name

Successor Trustees for Client (applicable for trusts)

Name

SPOUSE/PARTNER'S TRUSTEES

Initial Trustee for Spouse/Partner (applicable for trusts)

Name

Successor Trustees for Spouse/Partner (applicable for trusts)

Name

VI. CLIENT'S HEALTH CARE DIRECTIVES

Do you have a current Living Will? □ Yes □ No If yes, date: ______________

Do you have a current Health Care Directive (also called Health Care Power of Attorneys)?

□ Yes □ No If yes, date: ________________

Do you have a HIPAA Authorization? □ Yes □ No If yes, date: ______________

IF YOU DO NOT HAVE A LIVING WILL OR HEALTH CARE DIRECTIVE OR YOUR DOCUMENTS ARE OLDER THAN THREE (3) YEARS OLD, PLEASE COMPLETE THE FOLLOWING:

In preparing a Living Will or Health Care Directive, would you want to provide for continued nutrition/hydration (food/water) if your death was imminent? □ Yes □ No

Primary Health Care Agent(s)

Name	Address	City	State	Zip	Phone

Alternate Health Care Agent(s)

Name	Address	City	State	Zip	Phone

VII. SPOUSE'S HEALTH CARE DIRECTIVES

Do you have a current Living Will? □ Yes □ No If yes, date: _____________

Do you have a current Health Care Directive (also called Health Care Power of Attorneys)?

□ Yes □ No If yes, date: _______________

Do you have a HIPAA Authorization? □ Yes □ No If yes, date: _____________

IF YOU DO NOT HAVE A LIVING WILL OR HEALTH CARE DIRECTIVE OR YOUR DOCUMENTS ARE OLDER THAN THREE (3) YEARS OLD, PLEASE COMPLETE THE FOLLOWING:

In preparing a Living Will or Health Care Directive, would you want to provide for continued nutrition/hydration (food/water) if your death was imminent? □ Yes □ No

Primary Health Care Agent(s)

Name	Address	City	State	Zip	Phone

Alternate Health Care Agent(s)

Name	Address	City	State	Zip	Phone

VIII. CLIENT'S DURABLE POWER OF ATTORNEY

Primary Agent(s)

Name	Address	City	State	Zip	Phone

Alternate Agent(s)

Name	Address	City	State	Zip	Phone

IX. SPOUSE'S DURABLE POWER OF ATTORNEY

Primary Agent(s)

Name	Address	City	State	Zip	Phone

Alternate Agent(s)

Name	Address	City	State	Zip	Phone

X. ASSETS AND LIABILITIES

Personal Net Worth (combined): $___________________

Client Annual Income: $____________________

Spouse Annual Income: $___________________

Client has interest in qualified pension plan(s)? □ Yes □ No

Spouse/Partner has interest in qualified pension plan(s)? □ Yes □ No

XI. FINANCIAL SUMMARY

Instructions: Please complete the following. If any property is the separate property of spouse, please write "SP" in the SP/CP column. If the property is community property, write "CP" instead. If you have a current financial statement, please attach it, but complete this listing as well as it does require more detail.

A. SAVINGS / CHECKING ACCOUNTS: List each financial institution, the account number, and the approximate total value of deposits.

	Institution	**Account Number**	**Owner(s)**	**SP/CP**	**Approx. Balance**
(a)					
(b)					
(c)					
(d)					
(e)					
(f)					

B. **BROKERAGE ACCOUNTS**: List each brokerage account, the account number, and the approximate total value of investments with that broker.

	Institution	Account Number	Owner(s)	SP/CP	Approx. Balance
(a)					
(b)					
(c)					
(d)					
(e)					
(f)					

C. **RETIREMENT / IRA ACCOUNTS**: List institutions, account numbers, and approximate value of each account.

	Institution	Account Number	Participant/Owner(s)	SP/CP	Value
(a)					
(b)					
(c)					
(d)					
(e)					
(f)					

D. **REAL ESTATE**: List property(ies) and the approximate value of each property.

	Location	**Owner(s)**	**SP/CP**	**Approx. Value**
(a)				
(b)				
(c)				
(d)				
(e)				
(f)				

E. **LIFE INSURANCE POLICIES**:

(1) Company: ______________________

Policy #: ______________________

Policy Type: ______________________

Insured: ______________________

Owner: ______________________

Beneficiary: ______________________

Death Benefit: ______________________

Cash Value: ______________________

(2) Company: ______________________

Policy #: ______________________

Policy Type: ______________________

Insured: ______________________

Owner: ______________________

Beneficiary: ______________________

Death Benefit: ______________________

Cash Value: ______________________

(3) Company: ______________________

Policy #: ______________________

Policy Type: ______________________

Insured: ______________________

Owner: ______________________

Beneficiary: ______________________

Death Benefit: ______________________

Cash Value: ______________________

(4) Company: ______________________

Policy #: ______________________

Policy Type: ______________________

Insured: ______________________

Owner: ______________________

Beneficiary: ______________________

Death Benefit: ______________________

Cash Value: ______________________

F. **BUSINESS(ES) OR ENTITY(IES) OWNED:**

Instructions: For each business or entity, please attach recent financial statements (balance sheet and a profit and loss for the most recent fiscal year). We will also need a statement attached which lists and describes the following matters for each entity:

(a) The entity's employer (or taxpayer) identification number and address;

(b) Any past or pending litigation (civil or criminal);

(c) Any threatened or potential future litigation (civil or criminal);

(d) Any past, present, or contemplated bankruptcy proceedings;

(e) Any executory contract obligations (i.e., responsibilities the entity has to fulfill under a contract), or any contracts in default;

(f) A description of the debts listed on the financial statements;

(g) Any debts, guarantees, or contingent liabilities not listed on the financial statements; and

(h) All property, casualty, and liability insurance carried by the entity, including coverage limits,

(i) and all changes to that insurance within the past two (2) years.

(1) Name of Business:

Entity type: ____

Owner:________________________________ SP/CP:________________

Percentage Owned: ______________ Approx. Value:______________

(2) Name of Business:

Entity type: ____

Owner:________________________________ SP/CP: ________________

Percentage Owned:______________ Approx. Value:______________

(3) Name of Business:

Entity type: ____

Owner:________________________________ SP/CP: ________________

Percentage Owned:______________ Approx. Value:______________

G. **<u>OTHER ASSETS</u>:** If you need additional space, please use the back of this sheet.

	Description	Owner(s)	SP/CP	Approx. Value
(a)				
(b)				
(c)				
(d)				
(e)				
(f)				

H. <u>LIABILITIES/DEBT (CONTINGENT/ACTUAL)</u>:

<u>Instructions</u>: "Liabilities" here include not only actual debts owed, but contingent liabilities (like guarantees) that may or may not come due in the future. It is important to list every contingent liability, no matter how remote the possibility. Please use the back of this sheet and/or attach other sheets for further description if necessary.

	Kind/Type	Person Responsible	Approximate Balance
(a)			
(b)			
(c)			
(d)			
(e)			
(f)			

XII. OTHER PLANNING ISSUES

	Client	Spouse/Partner
Want to benefit Charity?	Y / N	Y / N
Ownership in farm or ranch?	Y / N	Y / N
Ownership in Closely held business?	Y / N	Y / N
Ownership in Closely held business?	Y / N	Y / N
Own stock is Sub Chapter S corporation?	Y / N	Y / N
Ownership in a Medical, Dental or Veterinarian Practice?	Y / N	Y / N
Own a valuable collection? (e.g., art, stamp collections)	Y / N	Y / N
Owns interest in gas/oil?	Y / N	Y / N
Own a Primary Residence?	Y / N	Y / N
Own a Secondary Residence?	Y / N	Y / N
Own other significant interests in real estate?	Y / N	Y / N

XIII. MISCELLANEOUS

Do you have a safe-deposit box? ◻ Yes ◻ No

Location of safe-deposit box: ____

Location of important papers:__________ ____

Has Client made gifts to any one person exceeding $13,000 in any one calendar year?

◻ Yes ◻ No

Has Spouse/Partner made gifts to any one person exceeding $13,000 in any one calendar year?

◻ Yes ◻ No

Has Client ever filed a Federal Gift Tax Return? ◻ Yes ◻ No

If Yes, Years of Returns filed: ____

Has Spouse/Partner ever filed a Federal Gift Tax Return? ◻ Yes ◻ No

If Yes, Years of Returns filed: ____

Do you have any other legal issues of which I should be aware? ◻ Yes ◻ No

If Yes, please describe:

____

____

____

____