

**LAW OFFICE OF SAM M. (TREY) YATES, III, P.C**  
**ATTORNEY ~ MEDIATOR**

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**CLIENT INFORMATION FORM**  
**FOR WILL/ESTATE PLANNING MATTERS**

**\*\*\*\*PERSONAL AND CONFIDENTIAL\*\*\*\***

**Please fill out as completely.** If you lack some information, please make note of it and notify our office with the information as soon as possible. All information is strictly confidential

**YOUR NAME:**

\_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

\_\_\_\_\_  
Date of Birth Place of Birth (City and State)

**IDENTIFICATION #'S**

\_\_\_\_\_  
Social Security # State and Driver's License # (Attach a copy)

**RESIDENCE:**

\_\_\_\_\_  
Street City/State Zip Code

**MAILING ADDRESS:**

If different from residence \_\_\_\_\_  
Street City/State Zip Code

**COMMUNICATION:**

\_\_\_\_\_  
Home # Fax # @ Home e-mail @ home

\_\_\_\_\_  
Pager # Cell/Mobile #

\_\_\_\_\_  
Work # Fax # @ Work e-mail @ work

**OCCUPATION:**

\_\_\_\_\_  
Employer Address

**EMPLOYMENT:**

**POTENTIAL  
EXECUTOR/EXECUTRIX:**

\_\_\_\_\_  
(Last) (First) (Middle) (Maiden)  
( )  
\_\_\_\_\_  
Address City/State/Zip Telephone Number  
\_\_\_\_\_  
Age Date of Birth SS# Relationship

**1<sup>ST</sup> ALTERNATE:**

\_\_\_\_\_  
(Last) (First) (Middle) (Maiden)  
( )  
\_\_\_\_\_  
Address City/State/Zip Telephone Number  
\_\_\_\_\_  
Age Date of Birth SS# Relationship

**2<sup>ND</sup> ALTERNATE:**

\_\_\_\_\_  
(Last) (First) (Middle) (Maiden)  
( )  
\_\_\_\_\_  
Address City/State/Zip Telephone Number  
\_\_\_\_\_  
Age Date of Birth SS# Relationship

**POTENTIAL BENEFICIARY:**

\_\_\_\_\_  
(Last) (First) (Middle) (Maiden)  
( )  
\_\_\_\_\_  
Address City/State/Zip Telephone Number  
\_\_\_\_\_  
Age Date of Birth SS# Relationship

**SPECIFIC BEQUEST:**

\_\_\_\_\_  
Item Item Item Item Item

**PORTION OF ESTATE:**

\_\_\_\_\_  
Percent or Amount

**POTENTIAL BENEFICIARY:**

\_\_\_\_\_  
(Last) (First) (Middle) (Maiden)  
\_\_\_\_\_  
Address City/State/Zip ( ) Telephone Number

\_\_\_\_\_  
Age Date of Birth SS# Relationship

**SPECIFIC BEQUEST:**

\_\_\_\_\_  
Item Item Item Item Item

**PORTION OF ESTATE:**

\_\_\_\_\_  
Percent or Amount

**POTENTIAL BENEFICIARY:**

\_\_\_\_\_  
(Last) (First) (Middle) (Maiden)  
\_\_\_\_\_  
Address City/State/Zip ( ) Telephone Number

\_\_\_\_\_  
Age Date of Birth SS# Relationship

**SPECIFIC BEQUEST:**

\_\_\_\_\_  
Item Item Item Item Item

**PORTION OF ESTATE:**

\_\_\_\_\_  
Percent or Amount

**POTENTIAL BENEFICIARY:**

\_\_\_\_\_  
(Last) (First) (Middle) (Maiden)  
\_\_\_\_\_  
Address City/State/Zip ( ) Telephone Number

\_\_\_\_\_  
Age Date of Birth SS# Relationship

**SPECIFIC BEQUEST:**

\_\_\_\_\_  
Item Item Item Item Item

**PORTION OF ESTATE:**

\_\_\_\_\_  
Percent or Amount

**TRUST RECIPIENT:**

	(Last)	(First)	(Middle)	(Maiden)
				( )
Address	City/State/Zip		Telephone Number	
Age	Date of Birth	SS#	Relationship	

**TRUST RECIPIENT:**

	(Last)	(First)	(Middle)	(Maiden)
				( )
Address	City/State/Zip		Telephone Number	
Age	Date of Birth	SS#	Relationship	

**TRUST RECIPIENT:**

	(Last)	(First)	(Middle)	(Maiden)
				( )
Address	City/State/Zip		Telephone Number	
Age	Date of Birth	SS#	Relationship	

**If you would like to make other special bequest, we will need to know what items of your estate and to whom.**

Who do you want designated to make decisions regarding health and financial matters in the event of your incapacitation. If this is an individual not previously listed please provide the following information:

**Health Decisions:**

	(Last)	(First)	(Middle)	(Maiden)
				( )
Address	City/State/Zip		Telephone Number	

**Financial Decisions:**

	(Last)	(First)	(Middle)	(Maiden)
				( )
Address	City/State/Zip		Telephone Number	

**GUARDIANSHIP APPOINTMENT**

Do you need a Directive to Physician (Living Will) Yes No

Do you wish to be cremated? Yes No

Do you have specific funeral requests? If so please describe briefly: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I UNDERSTAND that a consultation fee of \$\_\_\_\_\_ will be charged.  
I ACKNOWLEDGE that a consultation fee will be paid upon my initial consultation.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Consultation fee received by: \_\_\_\_\_

Method of Payment: \_\_\_\_\_