

# The Law Office of Geri R. Wyatt

1102 Main Street  
Garland, Texas 75040  
(972) 265-9285 (telephone) (972)364-1272 (facsimile)  
geri@geriwyatt.com

## CLIENT INFORMATION WORKSHEET

### PART 1: PERSONAL DATA

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street Address: \_\_\_\_\_ SS#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_ Home #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Alias Names (if any): \_\_\_\_\_  
Are you a U.S. citizen? Yes: \_\_\_ No: \_\_\_

Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street Address: \_\_\_\_\_ SS#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_ Home #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Alias Names (if any): \_\_\_\_\_  
Is spouse a U.S. citizen? Yes: \_\_\_ No: \_\_\_

### CHILDREN'S INFORMATION:

Name	Living?	Age	Birthdate	Married?	City/State of Residence
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Name:	Relationship:	Living?	Residence:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please provide the following information regarding any former marriages:

Name of former spouse	Living?	Date of Death or Divorce
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Name of former spouse	Living?	Date of Death 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? \_\_\_\_\_





\_\_\_\_\_ percent at age \_\_\_\_\_  
\_\_\_\_\_ remaining share at age \_\_\_\_\_

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?

\_\_\_\_\_ Outright  
\_\_\_\_\_ In Trust until reach age \_\_\_\_, then outright  
\_\_\_\_\_ In Trust with distributions at various ages and amounts  
\_\_\_\_\_ percent at age \_\_\_\_\_  
\_\_\_\_\_ percent at age \_\_\_\_\_  
\_\_\_\_\_ percent at age \_\_\_\_\_  
\_\_\_\_\_ remaining share at age \_\_\_\_\_

Do you want the executor of your will to be compensated?

\_\_\_\_\_ Yes  
\_\_\_\_\_ No

Does your spouse want the executor of his/her will to be compensated?

\_\_\_\_\_ Yes  
\_\_\_\_\_ No

Do you want to include a provision regarding funeral arrangements? If so, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PART III-a - 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) – **Please also list this person's relationship to you.**

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) – **Please also describe your relationship to the Trustee.**

Name of Trustee: \_\_\_\_\_

1st Alternate Trustee: \_\_\_\_\_

2nd Alternate Trustee: \_\_\_\_\_

3rd Alternate Trustee: \_\_\_\_\_

**GUARDIAN OF MINOR CHILDREN** (i.e. the person who will take physical care of your minor children should both parents die) – **Please also describe the relationship between you and the Guardian.**

Name of Guardian: \_\_\_\_\_

1st Alternate Guardian: \_\_\_\_\_

2nd Alternate Guardian: \_\_\_\_\_

3rd Alternate Guardian: \_\_\_\_\_

**POWER OF ATTORNEY** (i.e., the person who will be responsible for handling your financial affairs in the event you become incapacitated)

Name of Power of Attorney: \_\_\_\_\_

Address: \_\_\_\_\_

Hm Phone No.: \_\_\_\_\_ Wk Phone No.: \_\_\_\_\_

Alternate Power of Attorney: \_\_\_\_\_

Address: \_\_\_\_\_

Hm Phone No.: \_\_\_\_\_ Wk Phone No.: \_\_\_\_\_

**HEALTH CARE AGENT** (i.e., the person who will make medical decisions for you in the event you are unable to make them for yourself.)

Name of Health Care Surrogate: \_\_\_\_\_

Address: \_\_\_\_\_

Hm Phone No.: \_\_\_\_\_ Wk Phone No.: \_\_\_\_\_

Alternate Health Care Surrogate: \_\_\_\_\_

Address: \_\_\_\_\_



Hm Phone No.: \_\_\_\_\_ Wk Phone No.: \_\_\_\_\_

**PART III-b - SPOUSE'S 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) **Please also list this person's relationship to you.**

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) **Please also describe your relationship to the Trustee.**

Name of Trustee: \_\_\_\_\_

1st Alternate Trustee: \_\_\_\_\_

2nd Alternate Trustee: \_\_\_\_\_

3rd Alternate Trustee: \_\_\_\_\_

**GUARDIAN OF MINOR CHILDREN** (i.e. the person who will take physical care of your minor children should both parents die) – **Please also list the relationship between yourself and the Guardian.**

Name of Guardian: \_\_\_\_\_

1st Alternate Guardian: \_\_\_\_\_

2nd Alternate Guardian: \_\_\_\_\_

3rd Alternate Guardian: \_\_\_\_\_

**POWER OF ATTORNEY** (i.e., the person who will be responsible for handling your financial affairs in the event you become incapacitated)

Name of Power of Attorney: \_\_\_\_\_

Address: \_\_\_\_\_

Hm Phone No.: \_\_\_\_\_ Wk Phone No.: \_\_\_\_\_

Alternate Power of Attorney: \_\_\_\_\_

Address: \_\_\_\_\_

Hm Phone No.: \_\_\_\_\_ Wk Phone No.: \_\_\_\_\_

**HEALTH CARE AGENT** (i.e., the person who will make medical decisions for you in the event you are unable to make them for yourself.)

Name of Health Care Surrogate: \_\_\_\_\_

Address: \_\_\_\_\_

Hm Phone No.: \_\_\_\_\_ Wk Phone No.: \_\_\_\_\_

Alternate Health Care Surrogate: \_\_\_\_\_

Address: \_\_\_\_\_

Hm Phone No.: \_\_\_\_\_ Wk Phone No.: \_\_\_\_\_

**YOUR LIVING WILL INFORMATION:**

Select the treatment provision you choose if you are suffering from an irreversible condition and cannot care for yourself or make medical conditions for yourself and you are expected to die without life sustaining treatment:

\_\_\_\_\_ Life-sustaining treatments discontinued

\_\_\_\_\_ Life-sustaining treatments continued

Select the treatment provision you choose if you are suffering from a terminal condition from which you are expected to die within six months, even with available life sustaining treatment:

\_\_\_\_\_ Life-sustaining treatments discontinued

\_\_\_\_\_ Life-sustaining treatments continued

Do you wish to provide additional requests regarding particular treatments? If so, please describe below: \_\_\_\_\_

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**YOUR SPOUSES' LIVING WILL INFORMATION:**

Select the treatment provision you spouse chooses if he/she is suffering from an irreversible condition and cannot care for him/herself or make medical conditions for him/herself and s/he is expected to die without life sustaining treatment:

- \_\_\_\_\_ Life-sustaining treatments discontinued
- \_\_\_\_\_ Life-sustaining treatments continued

Select the treatment provision your spouse chooses if s/he is suffering from a terminal condition from which s/he are expected to die within six months, even with available life sustaining treatment:

- \_\_\_\_\_ Life-sustaining treatments discontinued
- \_\_\_\_\_ Life-sustaining treatments continued

Do you wish to provide additional requests regarding particular treatments? If so, please describe below: \_\_\_\_\_

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