Amaral & Associates, P. C.
ATTORNEYS AT LAW

Client Estate Planning Intake Form

NAME: _____

DATE: _____

Client

First Name:	
Middle Name:	
Last Name:	
Maiden Name:	
Date of Birth:	
Social Security Number:	
Street Address:	
City/Town:	
State & Zip Code:	
Home Phone:	
Cell Phone:	
Work Phone:	
Email:	

Client's Spouse

First Name:	
Middle Name:	
Last Name:	
Date of Birth:	
Social Security Number:	
Street Address:	
City/Town:	
State & Zip Code:	
Home Phone:	
Cell Phone:	
Work Phone:	
Email:	

Client's Children

Child 1

First Name:	
Middle Name:	
Last Name:	
Date of Birth:	
Social Security Number:	
Street Address	
City/Town:	
State & Zip Code:	
Home Phone:	
Cell Phone:	
Work Phone:	

Child 2

First Name:	
Middle Name:	
Last Name:	
Date of Birth:	
Social Security Number:	
Street Address	
City/Town:	
State & Zip Code:	
Home Phone:	
Cell Phone:	
Work Phone:	

Child 3

First Name:	
Middle Name:	
Last Name:	
Date of Birth:	
Social Security Number:	
Street Address	
City/Town:	
State & Zip Code:	
Home Phone:	
Cell Phone:	
Work Phone:	

Child 4

First Name:	
Middle Name:	
Last Name:	
Date of Birth:	
Social Security Number:	
Street Address	
City/Town:	
State & Zip Code:	
Home Phone:	
Cell Phone:	
Work Phone:	

Child 5

First Name:	
Middle Name:	
Last Name:	
Date of Birth:	
Social Security Number:	
Street Address	
City/Town:	
State & Zip Code:	
Home Phone:	
Cell Phone:	
Work Phone:	

Beneficiaries of the Will

(In your will, you must name a primary beneficiary and a contingent beneficiary of your entire estate. This can be your spouse, your children, your parents, your siblings, or someone else.)

Primary Beneficiary		
Who do you want to primarily leave your estate to?	Spouse ☐ Children ☐ Trust ☐ Other ☐	
If you want to leave your estate to someone else, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	

Contingent Beneficiary		
Who do you want to your contingent beneficiary of your entire estate to be?	Spouse ☐ Children ☐ Trust ☐ Other ☐	
If you want to leave your estate to someone else, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	

Residuary Estate

(This is commonly known as a catch basin clause. Even though you are naming a primary and contingent beneficiary, the residuary estate is used for the rest of your estate, in case any of your property was not included in the rest of your will. For this, you also have to name a primary beneficiary and a contingent beneficiary. It can be the same people you have listed above, or someone else.)

Primary Beneficiary		
Who do you want to primarily leave your residuary estate to?	Spouse ☐ Children ☐ Other ☐ Trust ☐ Heirs at Law ☐	
If you want to leave your estate to someone else, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	

Contingent Beneficiary		
Who do you want to your contingent beneficiary of your residuary estate to be?	Spouse ☐ Children ☐ Other ☐	
If you want to leave your estate to someone else, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	

Beneficiaries of Real Estate

(If you own real estate and want to leave it to a specific person, please provide the information below.)

Primary Residence	
Street Address	
City, County, State	
Name(s) on title	
Full name of beneficiary:	
Beneficiary Street Address	
Beneficiary City/Town:	
Beneficiary State & Zip Code:	
Vacation or Second Home	
Street Address	
City, County, State	
Name(s) on title	
Full name of beneficiary:	
Beneficiary Street Address	
Beneficiary City/Town:	
Beneficiary State & Zip Code:	
Other Real Estate	
Street Address	
City, County, State	
Name(s) on title	
Full name of beneficiary:	
Beneficiary Street Address	
Beneficiary City/Town:	
Beneficiary State & Zip Code:	

Beneficiaries of Personal Property

(If you want to leave your personal property to a specific person, please provide the information below.)

Primary Beneficiary		
Who do you want to primarily leave your personal property to?	Spouse ☐ Children ☐ Other ☐	
If you want to leave your estate to someone else, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	
Contingent Beneficiary		
Who do you want to be your contingent beneficiary if your primary beneficiary is unable to inherit?	Spouse ☐ Children ☐ Other ☐	
If you want to leave your estate to someone else, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	

Specific Bequests

(If you have any specific items or bequests, please list them here.)

Specific Bequest #1		
Description of property:		
Who do you want to leave this to?	Spouse ☐ Children ☐ Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	
Specific Bequest #2		
Description of property:		
Who do you want to leave this to?	Spouse ☐ Children ☐ Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	

Specific Bequest #3		
Description of property:		
Who do you want to leave this to?	Spouse ☐ Children ☐ Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	
Specific Bequest #4		
Description of property:		
Who do you want to leave this to?	Spouse ☐ Children ☐ Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Notes:	

Personal Representative

(person whom testator/testatrix delegates responsibility for carrying out the terms of this will.)

Primary Personal Representative		
Who do you want to manage your estate pursuant to your will?	Spouse ☐ Children ☐ (identify which child) Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Relationship to you:	
Contingent Personal Representative		
Who do you want to manage your estate pursuant to your will if your primary personal representative is unable to do so?	Spouse ☐ Children ☐ (identify which child) Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Relationship to you:	

Guardian

(If you have children under the age of 18, you should appoint a guardian or co-guardian to care for your children in the event that you or your or the other parent either die or are unable to care for your children.)

Primary Guardian	
Full name:	
Street Address:	
City/Town:	
State & Zip Code:	
Relationship to you:	
Alternate Guardian	
Full name:	
Street Address:	
City/Town:	
State & Zip Code:	
Relationship to you:	

Intentional Exclusions

(Names of person(s) or organizations that you intentionally want to exclude from receiving your assets under this will, if any.)

Exclusion #1	
Full name:	
Street Address:	
City/Town:	
State & Zip Code:	
Relationship to you:	
Exclusion #2	
Full name:	
Street Address:	
City/Town:	
State & Zip Code:	
Relationship to you:	

Health Care Proxy

(A Health Care Proxy is a document that authorizes someone you trust to make medical decisions on your behalf when you are unable to do so.)

Primary Health Care Agent		
Who do you want to primarily make your medical decisions?	Spouse ☐ Children ☐ (identify which child) Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Home phone:	
	Cell phone:	
	Work phone:	
	Relationship to you:	
Alternate Health Care Agent		
Who do you want to make your medical decisions if your primary agent is unable to?	Spouse ☐ Children ☐ (identify which child) Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Home phone:	
	Cell phone:	
	Work phone:	
	Relationship to you:	

Second Alternate Health Care Agent (Optional)		
Who do you want to make your medical decisions if your primary agent and alternate agent are unable to?	Spouse ☐ Children ☐ (identify which child) Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Home phone:	
	Cell phone:	
	Work phone:	
	Relationship to you:	

Authority of Health Care Agent

Are there any limitations you would like to place on your Agent or Alternate Agent?	Yes ☐ No ☐
If yes, please specify:	
Are there any other specific instructions or requests you would like to make relative to your health care?	Yes ☐ No ☐
If yes, please specify:	

Living Will

(A Living Will is a document that you sign that states your preferences regarding extraordinary medical measures and end of life care. Under Massachusetts law, a Living Will is not legally binding, but it is instructive in the event of a dispute regarding your medical care.)

Would you like a Living Will?	Yes ☐ No ☐
Do you want to include a directive about end of life treatment?	Yes ☐ No ☐
If you become permanently unconscious, do you want life-sustaining procedures withheld and withdrawn?	Yes ☐ No ☐
Do you want to receive artificially provided food and fluids?	Yes ☐ No ☐
If applicable, do you want to include language in the event you become pregnant?	Yes ☐ No ☐ N/A ☐
If applicable, if the fetus could not survive, should your life-sustaining procedures be withheld and withdrawn?	Yes ☐ No ☐ N/A ☐
If applicable, if you are pregnant, should your pain or physical harm be considered in determining whether or not life-sustaining procedures should be withheld or withdrawn?	Yes ☐ No ☐ N/A ☐

Power of Attorney

(This document appoints somebody who you trust to manage your property, business, and financial affairs, in the event you become ill or incapacitated)

Primary Attorney		
Who do you want to be your primary attorney-in-fact?	Spouse ☐ Children ☐ (identify which child) Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Home phone:	
	Cell phone:	
	Work phone:	
	Relationship to you:	
Alternate Attorney		
Who do you want to be your alternate attorney-in-fact if your primary attorney-in-fact is unable to?	Spouse ☐ Children ☐ (identify which child) Other ☐	
If other, please provide the following:	Full name:	
	Street Address:	
	City/Town:	
	State & Zip Code:	
	Home phone:	
	Cell phone:	
	Work phone:	
	Relationship to you:	

Authority of Attorney

Are there any limitations you would like to place on your Attorney?	Yes ☐ No ☐
If yes, please specify:	
When do you want your Power of Attorney to become effective?	☐ Immediately ☐ Upon a specific date (Date: _____) ☐ Upon certification by a physician that you are disabled or lack mental competence.
When do you want your Power of Attorney to terminate?	☐Upon your death ☐On a specific date (Date: _____)