PAUL SCOTT

ATTORNEY AT LAW

CLIENT QUESTIONNAIRE

HOW DID YOU HEAR ABOUT US? (CIRCLE ONE)

WEBSITE FACEBOOK GOOGLE REFERRAL_____OTHER _____

CLIENT INFORMATION

Full Name (First/Middle/Last): _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Email: _____

Employer: _____ Position: _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Gross Weekly Income: _____ Income reported on last year's taxes: _____

County Residing In: _____ Length of Residence in State: _____

Driver's License # _____ Date of Birth: _____

Place of Birth (City, State): _____

Level of Education (Circle One): HS BA/BS MASTERS PhD/DOCTORATE

Social Security Number: _____

PLEASE LIST ANY:

Criminal Convictions: _____

Alcohol/Drug Abuse: _____

Domestic Violence: _____

Anything else we should know? Please describe: _____

_____

_____

_____

OTHER PARTY INFORMATION

Full Name (First/Middle/Last): _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Email: _____

Employer: _____ Position: _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Gross Weekly Income: _____ Income reported on last year's taxes: _____

County Residing In: _____ Length of Residence in State: _____

Driver's License # _____ Date of Birth: _____

Place of Birth (City, State): _____

Level of Education (Circle One): HS BA/BS MASTERS PhD/DOCTORATE

Social Security Number: _____ Maiden Name: _____

PLEASE LIST ANY:

Criminal Convictions: _____

Alcohol/Drug Abuse: _____

Domestic Violence: _____

Anything else we should know? Please describe: _____

_____

_____

_____

CHILDREN

Full Name (First/Middle/Last) Birthdate School/Grade Social Security Number

_____

_____

_____

_____

If separated, state the current parenting time routine and for how long:

_____

_____

ANY OTHER MINOR CHILDREN RESIDING WITH EITHER PARTY:

Full Name (First/Middle/Last) Birthdate Residential Address Whose Child

_____

_____

HEALTH INSURANCE INFORMATION FOR CHILDREN:

Name of children: _____

Name of Policy Holder: _____

Name of Insurance CO/HMO: _____

Policy/Certificate/Contract No: _____

OTHER INSURANCE:

Name of children: _____

Name of Policy Holder: _____

Name of Insurance CO/HMO: _____

Policy/Certificate/Contract No: _____

OTHER TYPES OF INSURANCE AN PREMIUMS PAID:

_____

_____

HAS EITHER PARTY APPLIED FOR OR ARE RECEIVING PUBLIC ASSISTANCE? IF YES:

WHO IS RECEIVING TYPE OF ASSISTANCE (Bridge card, Medicaid, etc.) CASE#

_____

_____

IMPORTANT

IF YOU DO NOT WISH TO HAVE ANY MAIL SENT TO YOUR ADDRESS, SIGN HERE:

Signature:_____

Print Name:_____ Date:_____

IF SO, WE NEED AN ALTERNATE ADDRESS IN THE MEANTIME (I.E., FAMILY MEMBER, FRIEND, OR WORK). PLEASE PROVIDE:

Address:_____City:_____
State: _____ Zip: _____

IF YOU PREFER COURT DOCUMENTS TO BE SENT BY EMAIL, PLEASE PROVIDE:

Email Address: _____