



PROBATE INTAKE QUESTIONNAIRE

Please complete the following form. If you are unsure what to put or whether a question applies to your situation, you may leave it blank. Additionally, when giving information about a minor, please provide the email and phone number for the child's guardian instead of the child.

Today's Date: _____

BASIC PERSONAL INFORMATION

NAME OF DECEDENT: _____

PERMANENT RESIDENCE AT TIME OF DEATH (Prior to Nursing Home or Hospital):

CITY: _____ COUNTY: _____

STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ DATE OF DEATH: _____

SOCIAL SECURITY NUMBER: _____

WAS DECEDENT EVER ON MEDICAID? Yes No

WAS DECEDENT EVER ON MEDICARE? Yes No

LOCATION OF WILL, IF ANY:

DATE OF WILL: _____

LOCATION OF CODICIL, IF ANY: _____

DATE OF CODICIL: _____

ESTATE REPRESENTATION / EXECUTOR / ADMINISTRATOR

PERSONAL REPRESENTATIVE (NAMED IN WILL OR PROPOSED): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

TELEPHONE: _____

RELATIONSHIP TO DECEDENT: _____

ALTERNATE PERSONAL REPRESENTATIVE (NAMED OR PROPOSED):

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

TELEPHONE: _____

RELATIONSHIP TO DECEDENT: _____

BENEFICIARIES OR HEIRS AT LAW:

DECEDENT'S SPOUSE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

TELEPHONE: _____

DECEDENT'S CHILDREN:

CHILD # 1:

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

CHILD # 2:

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

CHILD # 3:

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

CHILD # 4:

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

CHILD # 5:

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

OTHER BENEFICIARIES (INCLUDE LIVING SIBLINGS AND LIVING PARENTS):

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

RELATIONSHIP TO THE DECEDENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

RELATIONSHIP TO THE DECEDENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

RELATIONSHIP TO THE DECEDENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

RELATIONSHIP TO THE DECEDENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ASSETS:

SAFE DEPOSIT BOX: Yes No

LOCATION: _____

REAL ESTATE:

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ DOD VALUE: _____

HOW TITLED: _____

HOMESTEAD: Yes No

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ DOD VALUE: _____

HOW TITLED: _____

HOMESTEAD: Yes No

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ DOD VALUE: _____

HOW TITLED: _____

HOMESTEAD: Yes No

STOCKS AND BONDS:

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

DATE OF DEATH VALUE: _____

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

DATE OF DEATH VALUE: _____

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

DATE OF DEATH VALUE: _____

BANK ACCOUNTS:

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

MONEY MARKET ACCOUNTS OR CERTIFICATES OF DEPOSIT:

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____



NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

U.S. GOVERNMENT SAVINGS BONDS (E, EE, H):

HOW TITLED: _____

LOCATION OF FONDS: _____

TO BE CASHED: Yes No

IF YES, NAME OF TRANSFEREE: _____

DATE OF DEATH VALUE: _____

MORTGAGES AND NOTES (RECEIVABLE):

MORTGAGOR 1: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TERMS OF OBLIGATION: _____

DATE OF DEATH VALUE: _____

MORTGAGOR 2: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TERMS OF OBLIGATION: _____

DATE OF DEATH VALUE: _____

INSURANCE ON DECENT'S LIFE:

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

ANNUITIES:

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

VEHICLES:

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

DATE OF DEATH VALUE: _____

MISCELLANEOUS PERSONAL PROPERTY:

DEBTS:

Please list all debts owed by the decedent, including the amount owed, at the time of their death. (Example of debts would be credit cards, automobile loans, home loans, doctor's bills, etc.)

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$: _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$: _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$: _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$: _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$: _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$: _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$: _____

OTHER QUESTIONS:

ARE ANY OF DECEDENT'S CHILDREN DISABLED? Yes No

IF YES, PLEASE LIST THE CHILD'S NAME AND NATURE OF DISABILITY: _____

DOCUMENTS NEEDED BY THIS OFFICE:

DEATH CERTIFICATE

COPY OF PAID FUNERAL BILL

COPIES OF ANY REAL ESTATE DEEDS

COPIES OF ANY VEHICLE TITLES

COPIES OF ANY BILLS

LAST WILL AND TESTAMENT (if one exists) *(Original Needed)*

PERSONAL REPRESENTATIVE:

HAS APPLICANT EVER BEEN CHARGED WITH, ARRESTED FOR OR CONVICTED OF A FELONY? Yes No

IF "YES" WAS ANSWERED, PLEASE GIVE DATE AND COMPLETE DETAILS: _____

HAS APPLICANT EVER BEEN CHARGED WITH, ARRESTED OR CONVICTED OF OTHER CRIMES? Yes No

IF "YES" WAS ANSWERED, PLEASE GIVE DATE AND COMPLETE DETAILS: _____

DOES APPLICANT HAVE ANY PHYSICAL DISABILITIES? Yes No

IF "YES" WAS ANSWERED, PLEASE EXPLAIN: _____

WILL ANY PHYSICAL DISABILITY LISTED ABOVE AFFECT ABILITY TO SERVE
AS PERSONAL REPRESENTATIVE? Yes No

HAS APPLICANT EVER BEEN TREATED FOR THE FOLLOWING?

MENTAL CONDITION Yes No

ALCOHOL Yes No

DRUGS Yes No

OTHER Yes No

NATURE OF CONDITION: _____

IF "YES" WAS ANSWERED TO ANY OF THE ABOVE, PLEASE STATE DATE, TIME, LOCATION OF TREATMENT, _____,

_____, _____ AND NAME OF PHYSICIAN OR PROFESSIONAL INVOLVED _____

PRINT NAME: _____

DATE: _____

You may submit this intake form by email to Sarah@EstateLawAtlanta.com. If you would prefer not to send your documents by email, please call the office at (404)736-6066 to arrange a secure transfer.