CLIENT INTAKE FORM INSTRUCTIONS – FAMILY LAW

Please complete this form as fully and accurately as possible. If you do not know the answer please place a question mark (?) in the space. If you know someone who knows the information please put their name in the space.

If at any time you need to update or correct the information please let my office know.

Information provided on this form is confidential and intended for the use by your attorney. It is protected by the attorney-client privilege, even if you choose not to retain my services, even where representation is never undertaken.

CLIENT CONSULTATION MEETING

Pleas	se note	that the	first 30) minutes	of your	first	consulta	tion	meeting	with	my	office	is
free.	For an	y time b	eyond t	he first 30) minute	s, you	u will be	char	ged at th	ne ho	urly	rate	

\$ 250/hour;			
Retainer: \$			

No Attorney-Client Relationship Created by Use of this Form:

Completing this form does not create an attorney-client relationship between you and William T. Tanner. Only a **signed engagement letter** creates an attorney-client relationship. I must first investigate for possible conflicts of interests (for example, I may already represent another party involved in your matter).

CLIENT INTAKE FORM – PATERNITY

PERSONAL INFORMATION

1.	FULL NAME:							
2.	SOCIAL SECURITY NUMBER:							
3.	DATE OF BIRTH (month/date/year):							
4.	ADDRESS WHERE THE CHILD RESIDES:							
	(street number & name) (city) (state) (zip) (county)							
5.	YOUR ADDRESS: (street number & name) (city) (state) (zip) (county)							
12.	(street number & name) (city) (state) (zip) (county) MAILING ADDRESS: (street number & name) (city) (state) (zip)							
10	PHONE NUMBER: (home) (work) (cell)							
14	E-MAIL ADDRESS*:							
	*We contact clients primarily through e-mail. If you would like to be contacted							
	in another manner, please specify:							
15	EMPLOYER NAME:							
	EMPLOYER ADDRESS:							
17	JOB TITLE:							
	ANNUAL INCOME:							
	DO YOU HAVE HEALTH INSURANCE? YES / NO							
20	HEALTH INSURANCE PROVIDER:							
INEOI	MATION ABOUT THE ADVERSE PARTY (AP)							
	• •							
	FULL NAME OF ADVERSE PARTY: A P'S DATE OF DIRTH (month/data/nom):							
3.	AP'S DATE OF BIRTH (month/date/year): FULL NAME AND ADDRESS OF AP'S ATTORNEY: (if the AP is representing him/herself, or if you do not know whether the AP has an attorney, please so indicate							
4.	ADDRESS OF AP:							
٦.	ADDRESS OF AP:							
5.	NAME OF AP'S EMPLOYER:							
6.	ADDRESS OF AP'S EMPLOYER:							
	(street number & name) (city) (state) (zip)							

7.	ANNUAL INCOME:
INFO	RMATION ABOUT YOUR CHILD(REN)
	NAMES AND BIRTH DATES OF ALL CHILDREN INVOLVED IN THIS CASE
•	
•	
•	
•	
•	
SPEC	CIAL CONCERNS
1.	Please describe any health concerns you or your child(ren) might have:
2	Diago describe the ignue(s) of another company to you relevant to this const
2.	Please describe the issue(s) of greatest concern to you relevant to this case:
PRIO	R LEGAL PROCEEDINGS
1.	Are there now or have there ever been any restraining orders between you and the other
	parent? YES / NO
	a. If so, from what court?
	b. When was the most recent order entered?
	c. What is the expiration date of that order?
	d. The name of your attorney?
2.	Have there been any other court actions between you and the other parent? <u>YES / NO</u>
	a. If so, in what court?
	b. What was the name of your attorney?
	c What orders has that court entered?

Law (Office of William T. Tanner
3.	Has the Department of Children and Families (formerly known as D.S.S. or the Department of Social Services), Department of Child Support Services been involved with you, your spouse or any child(ren) at issue? If so, when and why? YES / NO
	The state of the spouse of the state of the

IMPORTANT DOCUMENTS

If you retain the services of William T. Tanner, please provide to us as soon as possible documents relevant to the issues in your case.