HAIT & KUHN

ATTORNEYS AT LAW

WILL / HEALTH CARE INTAKE FORM

_____ _____

Last Name *First* *Maiden Name* *DOB*

_____

Street Address *Apt #* *City* ***County****State* *Zip Code*

( ) _____ *( )* _____ *( )* _____

Home Telephone *Work Telephone* *Cell /Other Phone*

Email Address: _____ *Fax No:* _____

*Drivers License No.:*_____ *Social Security No:* _____

_____ _____

Spouse Name *DOB*

_____

Street Address *Apt #* *City* ***County****/ State Zip Code*

( ) _____ *( )* _____ *( )* _____

Home Telephone *Work Telephone* *Cell /Other Phone*

Drivers License No.: _____ *Social Security No.:*_____

How were you referred to our offices? _____

Alternate Contact if unable to be reached: *Emergency Only)*

_____

WILL INFORMATION

Executor/rix: _____

Executor/rix (2) : _____

CHILDREN/HEIRS

Name	*DOB*	*Relationship*
Name	*DOB*	*Relationship*
Name	*DOB*	*Relationship*
Name	*DOB*	*Relationship*

REAL ESTATE

1. _____
Address *Titled*

2. _____
Address *Titled*

3. _____
Address *Titled*

AUTOMOBILES

_____

Year Make Model *Titled* *Heir*

Year Make Model *Titled* *Heir*

Year Make Model *Titled* *Heir*

SPECIFIC BEQUESTS

Type *Heir*

Type *Heir*

OTHER ASSETTS (IRA, MUTUAL FUNDS, STOCKS, BANK ACCOUNTS)

Type *Beneficiary*

Type *Beneficiary*

Type *Benficiary*

PENSION/ RETIREMENT PLANS

Type *Administrator* *Beneficiary*

Type *Administrator* *Beneficiary*

NOTES:

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DURABLE POWER OF HEALTH CARE INFORMATION

Health Care Agent

Name: _____

Address: _____

Phone: _____

Back-Up Health Care Agent

Name: _____

Address: _____

Phone: _____

Autopsy

Your Health Care agent will have the power to authorize an autopsy of your body unless you have limited their power.

Do you wish for your Health Care Agent to Have the power to authorize an autopsy of your body – should the question arise. _____ yes _____ no

Organ Donation / Donation of Body

Your Health Care agent will have the power to make disposition of any part or all of your body for medical unless you have limited their power.

Do you wish for your Health Care Agent to Have the power make a disposition of your body for use in a medical study program? _____ yes _____ no

Does your Heath Care Agent have the power to donate any of your organs? _____yes _____no

Final Disposition of Body

Your Health Care agent will have the power to make decisions about the final disposition of your body unless you wish for someone else to have that power.

Do you wish for your Health Care Agent to Have the power make decisions about the final disposition of your body? _____ yes _____ no

If your answer is no, please specify the name, address, and telephone number of the person with whom this authority is to be placed: _____
_____

Do you wish for your body to be: _____Buried _____Cremated

Treatment Preferences

This portion of the Georgia Advance Directive for Health Care will become effective under one or both of the following conditions:

A terminal condition, which means you have an incurable or irreversible condition that will result in your death in a relatively short period of time. _____yes _____no

A state of permanent unconsciousness, which means you are in an incurable or irreversible condition in which you are not aware of yourself or your environment and show no behavioral response to your environment. _____yes _____no

Please note that your condition will be determined in writing after personal examination by your attending physician and a second physician in accordance with currently accepted medical standards.

If you are in any condition listed above and you can no longer communicate your treatment preferences for any reason, then do you wish for one of the following

(A) Attempt to extend your life for as long as possible using medications, machines or other medical procedures, nutrition and/or fluids by tube or other medical means? _____yes _____no

OR

(B) Allow your death to occur naturally. No medications, no machines, or other medical procedures that would only keep you alive but not cure you. No nutrition or fluids by tube or other medical means except as needed to provide pain medication? _____yes _____no

OR

(C) No medications, machines, or other medical procedures, that would only keep me alive, but not cure me? _____yes _____no EXCEPT AS FOLLOWS (please choose all that apply):

_____ Nutrition by tube or other medical means – if not able to take by mouth

_____Fluids by tube or other medical means – if not able to take by mouth

_____Ventilator – if not able to breathe and need assistance

_____CPR – if heart or pulse has stopped

Any additional treatment that you would request (i.e. kept alive by support until family members arrive, the administration of medicine to alleviate pain, or the performance of any medical procedure deemed necessary to alleviate pain, etc.)

_____

_____

Pregnancy

Please note that under Georgia Law, the above medical preferences will have no force and effect if you are pregnant unless the fetus is not viable.

Do you wish for the above medical preferences to be carried out if your fetus is not viable? _____ yes _____ no

Guardianship

This is optional.

This is if you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointment. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your support, safety, and welfare. They will appoint the person nominated by you if the court finds that the appointment will serve in your best interest and welfare. Please state your preference: Do you wish for the person serving as your Health Care Agent above to serve as your guardian? _____ yes _____ no

*If your answer is no, please specify the name, address, and telephone number of the person whom you wish to nominate as your guardian:*_____
_____

Back-up Guardian: Name: _____

Address: _____

Phone: _____

NOTES:

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