

Financial Need Assessment Sheet!

1 Name: _____ Date: _____

2 Address: _____

3 Telephone #: Business: _____ Cell: _____ Home: _____

4 Age: _____ Dae of Birth: _____ Married: Yes No

5 Are you a U.S. citizen? Yes No Is your spouse: Yes No

6 Number of children: _____ Ages: _____

How many children live with you? _____

Do you have children outside your current marriage? Yes No

7 Do you have a trust? Yes No When was it last updated? _____

8 Do you have an existing qualified plan? Yes No

If yes, what kind is it? _____

When was it implemented? _____

What is the value of the plan? \$ _____

9 Do you have life insurance? Yes No

What kind? _____

What is the benefit amount? \$ _____

10 Do you have a family limited partnership? Yes No

11 What other investments assets do you have? (Real Estate, Securities, Bonds, Annuities, etc.)

12 Are your investment assets held in an entity or by you as an individual? _____

13 What is your net worth? \$ _____

14 What is yor personal income from your practice? \$ _____

Gross: \$ _____

Net (after expenses, but before taxes): \$ _____

15 Do you have income from sources other than the medical practice? Yes No
If yes, from what, and what is the annual gross income? \$ _____
What is annual net income (after expenses, but before taxes): \$ _____

16 How likely is it that you or your wife will inherit significant assets or qualified plan assets?

17 How concerned about assets protection are you?
High _____
Medium high _____
Medium _____
Low _____
Not at all _____

Practice Information:

18 Specialty: _____

19 Practice structure:
C Corporation _____
S Corporation _____
PLLC _____
LLC _____
GP _____

20 Number of physicians in your practice? _____
How many are partners? _____
How many are staff? _____

21 Number of employees? _____

22 Number of locations? _____

23 Comments: _____

