



The Law Office of Paul Whitcombe

815-288-7209

office@paulwhitcombe.com

223 West First Street, Dixon, IL 61021

15 East Third Street, Sterling, IL 61081

Paul T. Whitcombe, J.D.

Thomas A Whitcombe, J.D.

WILL/POWER OF ATTORNEY INTAKE SHEET

Consultation Date: _____

Consultation Fee is \$100

Please check each document you need:

____ Will

____ Power of Attorney – Healthcare

____ Power of Attorney – Property

____ Children’s Trust Will

Client Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ E-mail: _____

(Required)

Spouse Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ E-mail: _____

Executor

Agent for Healthcare

Agent for Property

Guardian

Child Full Name: _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **E-mail:** _____

- Executor Agent for Healthcare Primary Agent for Property Primary Guardian
 Agent for Healthcare Secondary Agent for Property Secondary

Child Full Name: _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **E-mail:** _____

- Executor Agent for Healthcare Primary Agent for Property Primary Guardian
 Agent for Healthcare Secondary Agent for Property Secondary

Child Full Name: _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **E-mail:** _____

- Executor Agent for Healthcare Primary Agent for Property Primary Guardian
 Agent for Healthcare Secondary Agent for Property Secondary

Child Full Name: _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **E-mail:** _____

- Executor Agent for Healthcare Primary Agent for Property Primary Guardian
 Agent for Healthcare Secondary Agent for Property Secondary

Child Full Name: _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **E-mail:** _____

- Executor Agent for Healthcare Primary Agent for Property Primary Guardian
 Agent for Healthcare Secondary Agent for Property Secondary

(If you are not the spouse or child, please complete below)

Executor Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Successor Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Agent Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Healthcare Primary Healthcare Secondary Property Primary Property Secondary

Agent Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Healthcare Primary Healthcare Secondary Property Primary Property Secondary

Guardian Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Successor Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

PRINT FORM

SAVE FORM

RESET FORM

