

WALDRON & SCHNEIDER, L.L.P.

A T T O R N E Y S A T L A W

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WILL FACT SHEET

Date: _____

Your Name _____ Email: _____
(First) (Middle) (Last)

Home Address _____ County _____
(Street) (City) (State) (Zip)

Home Phone _____ Mobile Phone _____

Date of Birth _____

Employer _____ Position _____

Business Address _____ Business Phone _____
(Street) (City) (State) (Zip)

Spouse's Name _____ Mobile Phone _____

Date of Birth _____ Date of Marriage _____

CHILDREN

Name _____ (M/F) _____ Date of Birth _____ Place of Birth _____
(First) (Middle) (Last)

If married, name of spouse _____
(First) (Middle) (Last)

Present Address, if different from yours _____
(Street) (City) (State) (Zip)

Name _____ (M/F) _____ Date of Birth _____ Place of Birth _____
(First) (Middle) (Last)

If married, name of spouse _____
(First) (Middle) (Last)

Present Address, if different from yours _____
(Street) (City) (State) (Zip)

Name _____ (M/F) _____ Date of Birth _____ Place of Birth _____
(First) (Middle) (Last)

If married, name of husband or wife _____
(First) (Middle) (Last)

Present Address, if different from yours _____
(Street) (City) (State) (Zip)

Property

Do you own any property outside of Texas? _____ Have either you or your wife inherited or do you expect to inherit any property?

To whom do you wish to leave your property: (all property or specific property?)

Executor _____

Alternate Executor _____

2nd Alternate Executor _____

Trust for Minor Children or Grandchildren

Trustee _____

Alternate Trustee _____

2nd Alternate Trustee _____

Guardian for Minor Children

Name _____ Address _____

Alternate Guardian _____ Address _____

2nd Alternate Guardian _____ Address _____

POWER OF ATTORNEY

Yes _____ No _____

Name of Designee _____ Phone # _____

Designee's address _____ County _____

Alternate Designee _____ Phone # _____

Designee's address _____ County _____

MEDICAL POWER OF ATTORNEY

Yes _____ No _____

Name of Designee _____ Phone # _____

Designee's address _____ County _____

Alternate Designee _____ Phone # _____

Designee's address _____ County _____

PHYSICIAN'S DIRECTIVE

Yes _____ No _____

If you prefer to include your Medical Power of Attorney in the Physician's Directive, please check below:

Yes _____ No _____

HIPPA

Yes _____ No _____

Name of Designee _____ Phone # _____

Designee's address _____ County _____

Name of Designee _____ Phone # _____

Designee's address _____ County _____

Name of Designee _____ Phone # _____

Designee's address _____ County _____