



10570 S Federal Highway 1 Ste 300 Port Saint Lucie, FL 34952
Office# (772) 236-5203 Fax# (772) 236-5201

CLIENT ASSESSMENT FORM
CONFIDENTIAL

CLIENT DEMOGRAPHIC INFORMATION

Tax Payer Name: _____ Spouse Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone Number: _____ Cell Phone Number _____ Email _____

Taxpayer

DOB: ____/____/____ SS# _____ - _____ - _____ Driver License # _____ EXP: ____/____/____

Taxpayer Spouse

DOB: ____/____/____ SS# _____ - _____ - _____ Driver License # _____ EXP: ____/____/____

Filing Status -Married• Single• Head of Household • What is your mother's maiden name? _____

Job Description / Position _____

Are you a Student: Yes/No _____ Full Time _____ Part Time Can you provide a 1098T ___ Yes ___ No

DEPENDENT INFORMATION

Children in Household: _____

1. Name: _____ DOB: ____/____/____ M/F SS# _____ - _____ - _____ Student: ___

2. Name: _____ DOB: ____/____/____ M/F SS# _____ - _____ - _____ Student: ___

3. Name: _____ DOB: ____/____/____ M/F SS# _____ - _____ - _____ Student: ___

Child Relationship to Taxpayer

1. _____ 2. _____ 3. _____

Any children in Daycare? ___ Yes ___ No
If yes please provide amount paid for the year \$ _____

Taxpayer Name

Signature

Date

Taxpayer Spouse Name

Spouse Signature

Date