

# IMPORTANT

## LEGAL AND PERSONAL

### INFORMATION

For my family and/or close personal friends:  
this information is provided  
so that you will have some personal  
information in event of a natural or man-  
made disaster or other tragedy.

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)

Info is current as of \_\_\_\_\_, 200\_\_.

Copies of important documents are attached:  
Wills, Living Wills, Powers of Attorney.

### HINDSON & MELTON, LLC

400 Perimeter Center Terrace, Suite 900  
Atlanta, Georgia 30346

*Direct Dial:*

Karen Hindson (770) 350-9102  
Joy Melton (770) 512-8383

[karen@hindsonmelton.com](mailto:karen@hindsonmelton.com)  
[melton@hindsonmelton.com](mailto:melton@hindsonmelton.com)

Visit our Web Site at:

[www.hindsonmelton.com](http://www.hindsonmelton.com)  
© Hindson & Melton, LLC 2005

## Family member 1:

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Birth Certificate is located \_\_\_\_\_

Last Will and Testament Date: \_\_\_\_\_

Original Last Will and Testament is located \_\_\_\_\_

Safety Deposit Box (if applicable) is located \_\_\_\_\_

DD 214 (if applicable – military service)  
is located \_\_\_\_\_

Life insurance policies:

Company \_\_\_\_\_

Policy number \_\_\_\_\_

Contact phone \_\_\_\_\_

Company \_\_\_\_\_

Policy number \_\_\_\_\_

Contact phone \_\_\_\_\_

Living Will? (yes) (no) Date: \_\_\_\_\_

Original is located \_\_\_\_\_

Health care power of attorney or other  
advance directive? (yes) (no) Date: \_\_\_\_\_

Original located: \_\_\_\_\_

Chronic medical conditions, medications,  
physicians' names and numbers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Other information:

Banking relationships:

\_\_\_\_\_  
\_\_\_\_\_

Investment Relationships:

\_\_\_\_\_  
\_\_\_\_\_

Dental records are located:

\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Provider/policy #:

\_\_\_\_\_  
\_\_\_\_\_

Employment or retirement benefits contact:

\_\_\_\_\_  
\_\_\_\_\_

Family Contact Numbers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family member 2:

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Birth Certificate is located \_\_\_\_\_

Last Will and Testament Date: \_\_\_\_\_

Original Last Will and Testament is located \_\_\_\_\_

Safety Deposit Box (if applicable) is located \_\_\_\_\_

DD 214 (if applicable – military service) is located \_\_\_\_\_

Life insurance policies:

Company \_\_\_\_\_

Policy number \_\_\_\_\_

Contact phone \_\_\_\_\_

Company \_\_\_\_\_

Policy number \_\_\_\_\_

Contact phone \_\_\_\_\_

Living Will? (yes) (no) Date: \_\_\_\_\_

Original is located \_\_\_\_\_

Health care power of attorney or other advance directive? (yes) (no) Date: \_\_\_\_\_

Original located: \_\_\_\_\_

Chronic medical conditions, medications, physicians' names and numbers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family member 3:

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Birth Certificate is located \_\_\_\_\_

Last Will and Testament Date: \_\_\_\_\_

Original Last Will and Testament is located \_\_\_\_\_

Safety Deposit Box (if applicable) is located \_\_\_\_\_

DD 214 (if applicable – military service) is located \_\_\_\_\_

Life insurance policies:

Company \_\_\_\_\_

Policy number \_\_\_\_\_

Contact phone \_\_\_\_\_

Company \_\_\_\_\_

Policy number \_\_\_\_\_

Contact phone \_\_\_\_\_

Living Will? (yes) (no) Date: \_\_\_\_\_

Original is located \_\_\_\_\_

Health care power of attorney or other advance directive? (yes) (no) Date: \_\_\_\_\_

Original located: \_\_\_\_\_

Chronic medical conditions, medications, physicians' names and numbers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family member 4:

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Birth Certificate is located \_\_\_\_\_

Last Will and Testament Date: \_\_\_\_\_

Original Last Will and Testament is located \_\_\_\_\_

Safety Deposit Box (if applicable) is located \_\_\_\_\_

DD 214 (if applicable – military service) is located \_\_\_\_\_

Life insurance policies:

Company \_\_\_\_\_

Policy number \_\_\_\_\_

Contact phone \_\_\_\_\_

Company \_\_\_\_\_

Policy number \_\_\_\_\_

Contact phone \_\_\_\_\_

Living Will? (yes) (no) Date: \_\_\_\_\_

Original is located \_\_\_\_\_

Health care power of attorney or other advance directive? (yes) (no) Date: \_\_\_\_\_

Original located: \_\_\_\_\_

Chronic medical conditions, medications, physicians' names and numbers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_