Power of Attorney Services Application Form

Name:_____

Date:_____ SSN:_____ Age:_____ DOB: _____
Address:_____ Phone number:_____

Health Insurance carrier:_____ Policy number:_____
Secondary:_____ Policy number:_____

Do you need a: □Medical POA □Financial POA □Both

Do you: (please circle)

- Have living family? YES NO

If yes, please list names, contact info and relationships_____
_____
_____
_____
_____

If checked, please provide a copy to WGC

Do you:

□ Have a living will?
□ Have a Will?
□ Have written Advance Directives?
□ Have a burial plan?

Name & phone number of your primary care physician: _____
Date you were last seen: _____

Please list any diagnosis or medical conditions that you have:_____
_____

_____
_____

Please list any medications that you take including dosage:_____
_____
_____
_____
_____

What is the name of your Attorney?_____ Phone #_____

Other important information that we should know about you:

_____
_____
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For Financial Power of Attorney:

At what institutions do you have the following:

Checking:_____ Estimated worth:_____

Savings:_____ Estimate worth:_____

Investments:_____ Estimated worth:_____

CD's:_____ Estimated worth:_____

Safety Deposit Box (s):_____ Contents:_____

_____

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Trust:_____ Estimated worth:_____

Please list the addresses of properties you own:

1.
2.
3.
4.
5.

Please list significant debts that you owe (mortgages, vehicle loans etc)

1.
2.
3.
4.
5.

For Medical Power of Attorney

1. Do you consider yourself to have a disability or other disabling medical condition? YES/NO if yes, what?
2. Have you ever had an operation or serious illness? YES/NO if yes, what?
3. Have you been seen or treated by a doctor or any other health professional in the past two years (other than for minor ailments or vaccinations)?
YES/NO Please list:
4. Do you have diabetes? YES/NO
5. Have you ever had epilepsy or seizures? YES/NO
6. Have you ever had back/neck problems? YES/NO
7. Do you have arthritis, joint or limb problems? YES/NO
8. Have you ever suffered from depression, anxiety or other psychological problems? YES/NO
9a Have you ever seen a doctor or health professional because of eating problems? YES/NO
9b Have you ever been diagnosed with an eating disorder? YES/NO
10. Do you have hearing loss or other ear problems? YES/NO
11. Do you have any eyesight problem (which is not corrected by glasses or contact lenses)? YES/NO
13. Do you have any allergies? YES/NO if yes, what?
14 Do you have dyslexia or another specific learning difficulty? YES/NO
15.. Do you have asthma or another breathing condition? YES/NO
17. Have you had TB or been in recent contact with open TB? YES/NO
18. Have you ever had a skin problem? If so, which part of the body was/is affected? YES/NO If yes, what?
19. Have you ever had hepatitis? YES/NO
20. Do you have frequent diarrhea or any other bowel disorder? YES/NO
21. Have you ever had a health problem caused by your work or study? YES/NO
26. Do you smoke? If yes, how many per day_____ YES/NO
27. Do you drink alcohol? If yes, how much in an average week? YES/NO
28. Do you have any condition or receive any treatment that affects how your immune system

works? E.g. Cancer treatment, steroids or HIV, autoimmune disease.
YES/NO If yes, what?
29. Do you have a blood borne virus e.g. Hepatitis B/C or HIV? YES/NO If yes, what?

Clients with specific health issues or disabilities are encouraged to enclose copies of any relevant reports from their GP/family doctor/consultant/specialist to ensure the most thorough and best available services possible.

Question Details (including dates, treatment received, how it affects you now etc.) can be elaborated on
here:_____
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