



## Taxpayer Questionnaire

PERSONAL INFORMATION					
Primary Taxpayer					
First Name:	Last Name:	M.I.:			
S.S.N.:	Birth date:	Taxpayer's Identity PIN, if applicable:			
Home Phone:	Work Phone:	Cell Phone:			
Occupation:	Dependent on another return? <input type="checkbox"/> Yes <input type="checkbox"/> No	Legally Blind?	Disabled?		
Email Address:	Text Message: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Phone Carrier:			
ID Number:	State:	Issue Date:	Expiry Date:		
Spouse					
First Name:	Last Name:	M.I.:			
S.S.N.:	Birth date:	Taxpayer's Identity PIN, if applicable:			
Home Phone:	Work Phone:	Cell Phone:			
Occupation:	Dependent on another return? <input type="checkbox"/> Yes <input type="checkbox"/> No	Legally Blind?	Disabled?		
Email Address:	Text Message: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Phone Carrier:			
ID Number:	State:	Issue Date:	Expiry Date:		
Filing Status					
Filing Status (Select the Checkbox, which Status number applies)  <input type="checkbox"/> 1 = Single <input type="checkbox"/> 2 = Married Filing Joint <input type="checkbox"/> 3 = Married Filing Separate <input type="checkbox"/> 4 = Head of Household <input type="checkbox"/> 5 = Qualified Widow(er)				<b>Notes</b>	
Referred by (New Client only):					
Address					
Street Address:		Apt. #.			
City:		State:		Zip Code:	
Military Address Info: (1 = APO/FPO, 2 = Stateside, 3 = Foreign or Blank)		Combat Zone:			
Bank Information (for Direct Deposit into Taxpayers Personal Acct.)					
Bank Name:		Account Type: <input type="checkbox"/> Saving <input type="checkbox"/> Checking			
Routing Number:		Account Number:			
Will this refund go to an account outside of the US? <input type="checkbox"/> Yes <input type="checkbox"/> No					
DEPENDENTS					
First Name	Last Name	Birth Date	SSN	Relationship	# of Months