

CLIENT QUESTIONNAIRE 2023 +

NAME	Mr.	Mrs
First name:	_____	
Last name:	_____	

NAME - SPOUSE	Mr.	Mrs
First name:	_____	
Last name:	_____	

IDENTIFICATION
Social Ins. Number: _____-_____-_____
Date of birth: (DD / MM / YY): ___ / ___ / ___

IDENTIFICATION - SPOUSE
Social Ins. Number: _____-_____-_____
Date of birth: (DD / MM / YY): ___ / ___ / ___

MARITAL STATUS
<input type="checkbox"/> Single <input type="checkbox"/> Common-law partner <input type="checkbox"/> Married) <input type="checkbox"/> Separated <input type="checkbox"/> Divorcee) <input type="checkbox"/> Widower
If your marital status has changed during the year: Old marital status: _____
Date of the change (DD / MM / YY): ___ / ___ / _____

CONTACT DETAILS
Phone: (____) ____ - _____
Mobile Phone : (____) ____ - _____
Address : _____ App. : _____
City: _____ Prov. : _____
Postal code: _____
E-mail : _____

CONTACT DETAILS - SPOUSE
Phone (____) ____ - _____
Phone Mobile:(____) ____ - _____ Check if the address is identical <input type="checkbox"/>
Will we process the spouse's return: <input type="checkbox"/> YES <input type="checkbox"/> NO
If not, give their approximate net income for the year \$ _____
E-mail : _____

- Have you lived alone for all tax year?(excluding dependents) YES NO
- Did you move during the tax year? YES NO
- Do you own more than \$ 100,000 in property abroad? YES NO
- Are you a Canadian citizen? YES NO
- Are you a non-resident of Canada for tax purposes? YES NO
- Did you buy a first home or sell your main residence? BOUGHT SOLD
- Do you want a technician to call you? NO If needed
- How would you like to receive a copy of your tax returns?
- Do you meet the eligibility criteria to claim home office expenses. If yes, please complete the section below. E-mail In person
YES NO

DRUG INSURANCE
Basic insurance (not complementary) covering drugs?
Government plan (RAMQ) From _____ at _____
My own group plan From _____ at _____
Spouse's / parent's plan From _____ at _____

DRUG INSURANCE - spouse
Basic insurance (not complementary) covering drugs?
Government plan (RAMQ) From _____ at _____
My own group plan From _____ at _____
Spouse's / parent's plan From _____ at _____

DEPENDENTS
M F First name: _____ Last name: _____
Date of birth: (DD / MM / YY): ___ / ___ / ___ SIN (if assigned): _____-_____-_____
M F Firstname name: _____
Date of birth: (DD / MM / YY): ___ / ___ / ___ SIN (if assigned): _____-_____-_____
M F First name: _____ Last name: _____
Date of birth: (DD / MM / YY): ___ / ___ / ___ SIN (if assigned): _____-_____-_____

Home office expenses
If you have a T2200S form, calculate the amount to which you are entitled <u>here</u> and enter it here