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consult $________

PATERNITY INFORMATION SHEET

Date of Consultation:__________________________ **Referred by:** __________________________

____

YOU

Full Name: ____ **Age:** __________

Maiden Name: ____________________________ **Social Security# (last 4 digits only)** _______________

Birthdate: ___________________ **D.L. # (last 4 digits only)** ______________ **State:** _____________

Place of Birth: ____

Home Address & County:____

Telephone Numbers: **(Work):** ________________________ **(Home):** _____________________________

Other numbers: **(Cell):** ________________________ **(Fax):** ______________________________

Business Name: ____

Business Address: ____

email Address: ____

Salary/Income: ____

____

OTHER PARTY

Full Name: ____ **Age:** __________

Maiden Name: ____________________________ **Social Security# (last 4 digits only)** _______________

Birthdate: ___________________ **D.L. # (last 4 digits only)** ______________ **State:** _____________

Place of Birth: ____

Home Address & County:____

Telephone Numbers: **(Work):** ________________________ **(Home):** _____________________________

Business Address: ____

email Address: ____

Salary/Income: ____

____

Next of Kin: ____ **Phone:** _______________

CHILDREN FROM THIS RELATIONSHIP UNDER 18:

Name	S.S. Number (last 4 digits only)	Sex	Birthdate	Birthplace
______________________________	_____________	___	________	__________
______________________________	_____________	___	________	__________
______________________________	_____________	___	________	__________
______________________________	_____________	___	________	__________
______________________________	_____________	___	________	__________

______ **Temporary Orders Desired?**
______ **Extraordinary Relief Desired?** ____
______ **Request Award of Attorney's Fees?**
______ **Waiver or Service?**

Has there been a paternity test to determine the identity of the father? ____________________

Do you desire a paternity test to determine the identity of the father? ____________________

Did the father sign the birth certificate? ____

If not, did someone else sign it? ____

Will there be a name change for the child(ren) and if so to what name(s): ____________________

____

Who is/are the child(ren) living with now and for what period of time: ____________________

____

____

Have you been to court before in this matter? ____

If so, when and Why? ____

____

Cause No. (Case No.) and County of case ____
(Please provide the latest order, if any.)

How many attorneys have you had? ____

Have many times have you been married? (Include any marriages annulled) ____________________

____

Have you ever been charged or convicted with a misdemeanor? If yes, please explain ______________

____

____

Have you ever been charged or convicted with a felony? If yes, please explain ________________

____

At what age did you graduate from high school? ____

NO. ___________

	§	**IN THE DISTRICT COURT**
___________________________________	§	**________ JUDICIAL DISTRICT**
___________________________________	§	**____________ COUNTY, TEXAS**

FINANCIAL INFORMATION STATEMENT

(Required in All Financial Hearings)

MONTHLY EXPENSES

	PRESENT
HOUSING	
House Mortgage/Rent	__________
Utilities (Gas, water, etc.)	__________
Maintenance & Repair	__________
Other _________________	__________
TRANSPORTATION	
Car Payment/Lease	__________
Gas, Oil, Maintenance	__________
Parking & Tolls	__________
INSURANCE	
Auto	__________
Life	__________
Medical	__________
Other _________________	__________
GROCERIES	
Food & Household Supplies	__________
YOUR PERSONAL	
Work Expenses:	
Lunches, etc.	__________
Dues, Fees, etc.	__________
Medical Expenses (not paid by ins):	
Drugs	__________
Doctors, Dentists	__________
Clothing	__________
Cleaning, Laundry	__________
Grooming	__________
Entertainment	__________
Current Child Support	__________
Other:	
______________________	__________
______________________	__________
CREDIT CARD/DEBTS	
______________________	__________
______________________	__________
Monthly Attorney Fees	__________

MONTHLY EXPENSES (cont.)

	PRESENT
YOUR CHILDREN	
Child Care	__________
School Tuition, Fees	
Lunches	__________
Supplies	__________
Medical Expenses (not covered by ins)	__________
Drugs	__________
Doctors, Dentists	__________
Grooming	__________
Entertainment Sports, Lessons, etc.	__________
Other: ______________________	__________
____________________________	__________
____________________________	__________
TOTAL EXPENSES	__________

INCOME: (attach current pay stubs)
[ ] paid monthly [ ] paid semi-monthly
[ ] paid weekly [ ] paid every two weeks

GROSS INCOME	
DEDUCTIONS	__________
Withholding Tax	__________
FICA	__________
Mandatory Retirement	__________
Medical Insurance	
Children	
Other Family	__________
Life Insurance	__________
Other	__________
OTHER	__________
LIQUID ASSETS	__________

I hereby certify that the answers to the above questions as listed are true and correct.

______________ Date ______________________ Signed

CAUSE NO. ______________

IN THE MATTER OF (INTEREST OF)	§	IN THE DISTRICT COURT
________________________________	§	
	§	OF DALLAS COUNTY, TEXAS
AND	§	
________________________________	§	_______ JUDICIAL DISTRICT

HEALTH INSURANCE AVAILABILITY FORM

Attention: This information must be filed with the court BEFORE first hearing.
See TEX FAM CODE § 154.181(b).

NAME OF PARTY: ____ ☐ MOVANT ☐ RESPONDENT

PARTY'S ATTORNEY (IF ANY): ______________________________

BESIDE THE NAME OF EACH CHILD, CHECK ALL TYPES OF HEALTH INSURANCE OR HEALTH CARE BENEFITS CURRENTLY COVERING THE CHILD(REN). YOU MAY CHECK MORE THAN ONE SOURCE.

NAME	DOB	SSN (LAST 4 DIGITS)	EMPLOYER PROVIDED FATHER'S	EMPLOYER PROVIDED MOTHER'S	PRIVATE	CHIP	OTHER	NONE
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

FOR EACH INSURANCE SOURCE PLEASE LIST THE FOLLOWING INFORMATION:
(ATTACH ADDITIONAL FORMS FOR EACH SOURCE OF BENEFITS)

A. NAME OF CARRIER ____
B. GROUP POLICY ID NUMBER ____
C. POLICYHOLDER NAME & ID NUMBER ____
D. NAME OF COVERED CHILD ____
E. COST/MONTH OF COVERAGE [CHILD{REN) ONLY] $_____________
(To determine coverage cost for child(ren), determine total cost for family coverage and subtract from this amount the cost to insure all covered individuals except the children.)

F. ARE YOU CURRENTLY PAYING THE PREMIUMS FOR LISTED MEDICAL BENEFITS? ☐ YES ☐ NO

STATE YOUR NET MONTHLY INCOME FROM YOR FINANCIAL INFORMATION STATEMENT: $___________

___________________________________ ___________________________
SIGNATURE OF PARTY COMPLETING FORM DATE

____
PRINTED NAME