THE COOLEY LAW FIRM

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NEW CLIENT INTAKE SHEET - NAME AND/OR GENDER MARKER CHANGE

DATE: _____ REFERRED BY_____

FULL LEGAL NAME AS REFLECTED ON BIRTH CERTIFICATE:

_____ _____ _____
First Middle Last

SEX AS REFLECTED ON BIRTH CERTIFICATE: □ MALE □ FEMALE

SOCIAL SECURITY NO.:_____DATE OF BIRTH & AGE:_____
STATE OF BIRTH: _____CITY OF BIRTH:_____
DRIVERS LICENSE NO. AND STATE:_____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ FAX:_____
E-MAIL ADDRESS:_____
DATE MOVED TO CLARK COUNTY, NEVADA: _____
HOME ADDRESS: _____
_____
EMPLOYER: _____ OCCUPATION: _____
WORK ADDRESS: _____
_____

NAME CHANGE:

NEW NAME:

_____ _____ _____
First Middle Last

REASON FOR NAME CHANGE:_____
_____
_____

□ Yes □ No Has Client Been Convicted of a Felony?

□ Yes □ No Is Client Changing Name to Defraud Creditors or Some Other Fraudulent Reason?

If client is a minor, please complete the following information: □ Not applicable/Client is an adult.

PARENT 1 FULL LEGAL NAME:_____

SOCIAL SECURITY NO.:_____DATE OF BIRTH:_____

DRIVERS LICENSE NO. AND STATE:_____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ FAX:_____

E-MAIL ADDRESS:_____

DATE MOVED TO CLARK COUNTY, NEVADA: _____

HOME ADDRESS: _____

_____

WILL PARENT CONSENT TO: NAME CHANGE?□Yes/□No/□N/A GENDER CHANGE?□Yes/□No/□N/A

PARENT 2 FULL LEGAL NAME:_____

SOCIAL SECURITY NO:_____DATE OF BIRTH:_____

DRIVERS LICENSE NO. AND STATE:_____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ FAX:_____

E-MAIL ADDRESS:_____

DATE MOVED TO CLARK COUNTY, NEVADA: _____

HOME ADDRESS: _____

_____

WILL PARENT CONSENT TO: NAME CHANGE?□Yes/□No □N/A GENDER CHANGE?□Yes/□No/□N/A

GENDER MARKER CHANGE:

Preferred Pronouns:☐ Gender-neutral (i.e., They/Their/Them)

☐ Gender-specific (☐He ☐ She)

☐ Use name (no pronouns)

Client wants to change gender marker from: □ MALE to FEMALE

□ FEMALE to MALE

1. Have you undergone sex-reassignment surgery? □YES □ NO

   If yes, If yes, please provide:

   Above the Belt/Top Surgery? □YES □ NO DATE:_____

   Below the Belt/Bottom Surgery? □YES □ NO DATE:_____

2. Are you living full-time as a □ MALE/□ FEMALE person? □YES □ NO
If yes, please provide DATE:_____

3. Are you undergoing (or have undergone) Hormone Therapy treatment to live as a □ MALE/ □ FEMALE person? □YES □ NO If yes, please provide DATE began:_____

4. What is your gender identification? □ MALE □ FEMALE □_____

5. Are you undergoing (or have undergone) clinical treatment for gender transition to the new gender with a physician licensed in the United States to continue to live as a □ MALE/□ FEMALE person? □YES □ NO DATE:_____ If yes, please provide:

Full Name of Physician:_____
Name of Hospital or Medical Clinic:_____
Physical Address:_____
Mailing Address:_____
Medical License/Certification Number and Issuing State:_____
OTHER INFORMATION YOU WISH TO BRING TO MY ATTENTION:
_____
_____
_____

EMERGENCY CONTACT:

Name (First, Last)	**Relationship**	**Address**	**Telephone**