

BOVITZ CPA, P.C.

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TAX DATA SHEET

DATE

FULL NAME <small>(Both, If Joint Return)</small>				E-MAIL				
ADDRESS			CITY		STATE		ZIP	
SCHOOL DISTRICT			COUNTY		HOME PHONE #			
OFFICE PHONE #	SOCIAL SECURITY #	DATE OF BIRTH	OCCUPATION	Driver License / ID # Issue Date: _____ Exp. Date: _____				
OFFICE PHONE #	SOCIAL SECURITY #	DATE OF BIRTH	OCCUPATION	Driver License / ID # Issue Date: _____ Exp. Date: _____				
Marital Status (on 12/31): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married <small>(Filing Separately)</small> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced								
DEPENDENTS (Not Husband or Wife):								
FIRST	FULL NAME <small>LAST</small>		LIVE IN YOUR HOME?	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATION- SHIP	STUDENT? Y / N	INCOME (DETAILS)

- YES NO PLEASE CHECK YES OR NO (if yes, submit details)
- Any interest or dividend income? Provide all 1099s.
 - Any unemployment income? Provide 1099 Gs.
 - Any sale of stock and/or real estate? Provide all 1099s including purchase/sale date and cost basis information.
 - Any social security received? Provide SSA1099s.
 - Any other income (inheritance, business, rental property, gambling), Provide details
 - Any pension income or distributions from retirement plans? Provide 1099 Rs.
 - Did you pay health insurance premiums? Provide medical costs summary
 - Did you pay child care (babysitting)? Provide ID# and amount, per payee.
 - Did you contribute to an IRA for this year? (M) ROTH _____ Traditional _____ (F) ROTH _____ Traditional _____
 - Did you pay college education costs for yourself or your dependents? Provide 1098T, 1099Q and Expenses.
 - Did you have charitable contributions? Please provide letter/summary
 - Did you pay property taxes? Provide tax bills or assessment letter.
 - Did you pay license tab fees? Provide amounts _____
 - Did you pay quarterly estimated taxes? Provide dates and amounts _____
 - Are you disabled? Describe _____
 - Marketplace health insurance for your family? Provide coverage information _____

Date: _____

X _____

THIS FORM MUST BE SIGNED AND DATED