South Dakota Department of Human Services
Client Screen - Print Out

Provider: South Dakota Counseling

	Local ID	* Last 4 SSN	* Birth Date	* Sex	* First 2 characters of Mothers First Name
Y *ROI*	08F-001	3333	02/02/1984	F	MA

First Name	MI	Last Name	Alias Name	Maiden Name	Medicaid #	SSN
Suzy		Client				

Address	City	County	State	Zip
1401 Minnesota St	Sioux Falls	Minnehaha	SD	57117

MH: Source Of Payment	ADA: Source Of Payment	Ethnicity	English Proficiency
	Other 3rd Party	Not of Hispanic Origin	Full

Primary Race	Secondary Race	Tertiary Race
White		

Home Phone	Work Phone	Cell Phone
(000) 000 - 0000	(000) 000 - 0000	(000) 000 - 0000

Mother's Information (Adolescent Clients Only)

First Name	MI	Last Name	Age	Home Phone #	Work Phone #
			0	(000) 000 - 0000	(000) 000 - 0000

Street Address	City	County of Residence	State	Zip
			SD	

Father's Information (Adolescent Clients Only)

First Name	MI	Last Name	Age	Home Phone #	Work Phone #
			0	(000) 000 - 0000	(000) 000 - 0000

Street Address	City	County of Residence	State	Zip
			SD	

Guardian's Information (Adolescent Clients Only)

First Name	MI	Last Name	Age	Home Phone #	Work Phone #
			0	(000) 000 - 0000	(000) 000 - 0000

Street Address	City	County of Residence	State	Zip
			SD	