HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway St.
Johnsonville, SC 29555
843-386-3573 Fax: 843-386-2617

1608 N. Main St.
Conway, SC 29526
843-248-4700 Fax: 843-248-3145

145 Palmetto Pointe Rd.
Marion, SC 29571
843-423-2400 Fax: 843-423-2070

REGISTRATION FORM

Patient Name:_____
Last Name First Middle

Address:_____ Apt. #: _____

City: _____ State: _____ Zip: _____ SS#: _____

Phone: _____ Fax: _____ Cell: _____ Voice : ☐ Text : ☐

Email: _____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

How would you like to receive reminders? ☐ Phone Call ☐ Text Message Use Above Number ☐ ☐ Email Use Above Address ☐

Other : _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ _____

Please check box if patient is under 18 years of age or a full time student: ☐

Place of Employment:_____ Work Phone: _____

Employer's Address: _____ City: _____ State:_____ Zip Code: _____

Spouse's Name: _____ Employer: _____ Phone #:_____

PLEASE NOTE: Payment is expected at the time of the visit.

I prefer to: ☐ Pay my balance in full at time of service ☐ Make payment arrangements prior to services being rendered

IF YOU HAVE INSURANCE OF ANY KIND, PLEASE PRESENT YOUR CARD(S) AT THE FRONT DESK FOR BILLING AND LAB PURPOSES.

Primary Insurance: _____ Currently on Sliding Fee Scale? ☐ Yes ☐ No

Policy #:_____ Group #_____ Subscriber's Birth date:_____

Subscriber's Employer:_____ Subscriber's Social Security Number:_____

Secondary Insurance: _____ Policy #:_____ Subscriber's Birth date:_____

Subscriber's Employer:_____ Subscriber's Social Security Number:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Who is responsible for this patient?

☐ Same As Above ☐ Other Than Above

Name:_____ Phone:_____ SS#:_____

Street:_____ City:_____ State: _____ Zip_____

Relationship to Patient: _____ Parent or Guardian Date of Birth:_____

How did you learn about HEALTH CARE PARTNERS? _____

I hereby certify that the income marked below for myself or the herein-named patient (for whom I am the parent or legal guardian) is accurate and current. I further understand that my medical information is confidential, but I authorize its release to my insurance companies, or as required by law.

Signature:_____ Date:_____

Family income data is needed by the government for us to get federal funding. It will not be shared with anyone else. Thanks for your help.

Family Size_____

□ 00,000 - $10,830	□ $29,530 - $33,269	□ $51,708 - $55,447	□ $74,148 - $77,887
□ $10,831 - $14,570	□ $33,270 - $37,009	□ $55,448 - $59,187	□ $77,888 - $81,627
□ $14,571 - $18,309	□ $37,010 - $40,749	□ $59,188 - $62,927	□ $81,628 - Above
□ $18,310 – $22,049	□ $40,750 – $44,488	□ $62,928 - $66,667	
□ $22,050 - $25,789	□ $44,489 - $48,227	□ $66,668 - $70,407	
□ $25,790 - $29,529	□ $48,228 - $51,707	□ $70,408 - $74,147	