# 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

**Previous Name (Marriage, Maiden, Other):**_____

**Address (Mailing):**_____ **Apt. #:**_____

City: _____ State: _____ Zip: _____

Street Address:(if different from mailing): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext:_____

**Preferred Reminders:** ☐ Voice Call -Home ☐ Voice Call -Cell ☐ Text Message (SMS)-Cell ☐ Patient Portal (Email needed)
☐ Opt out of all communications

**Type of Reminders- Voice:** ☐ Appointments ☐ Lab Results ☐ Health Maintenance ☐ General Notifications (i.e. facility closings)
**Type of Reminders- Text:** ☐ Appointments ☐ Lab Results ☐ Health Maintenance ☐ General Notifications (i.e. facility closings)

**Preferred Time to Call:** ☐ Morning ☐ Afternoon ☐ Evening

**Date of Birth:** _____ **Age:** _____ **Sex at birth:** ☐ Male ☐ Female ☐ Transgender

**Marital Status:** ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single ☐ Partner ☐ Legally Separated ☐ Unknown

SS#: _____ Employer Name:_____

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

Contact:_____ Employers Phone:_____

**Employment Status:** ☐ Full-time ☐ Part-time ☐ Not employed ☐ Self-employed ☐ Retired ☐ On active military duty
☐ Reserved for national assignment ☐ Unknown

**Student status:** ☐ full-time student: ☐ part- time student ☐ not a student

**Responsible Party/ Parent Information:** ☐ Same As Above ☐ Other Than Above

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?** Please fill out the information below and check the HIPAA box. You may revoke or modify an authorized member at any time but it must be in writing.

Name:_____ Phone:_____ SS#:_____

Street:_____ City:_____ State: _____ Zip_____

Relation to Patient: _____ Email:_____ ☐ Emergency Contact ☐ HIPAA

Name:_____ Phone:_____
Street:_____ City:_____ State: _____ Zip_____

Relation to Patient: _____ Email:_____ ☐ Emergency Contact ☐ HIPAA

Name:_____ Phone:_____

Street:_____ City:_____ State: _____ Zip_____

Relation to Patient: _____ Email:_____ ☐ Emergency Contact ☐ HIPAA

Name:_____Phone:_____

Street:_____City:_____State: _____Zip_____

Relation to Patient: _____ Email:_____ ☐ Emergency Contact ☐ HIPAA

Name:_____Phone:_____

Street:_____City:_____State: _____Zip_____

Relation to Patient: _____ Email:_____ ☐ Emergency Contact ☐ HIPAA

**PLEASE NOTE: Payment is expected at the time of the visit.** ☐ 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 Level:_____

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:_____

**Additional Information:** Email:_____ ☐ Does not have ☐ Will not disclose ☐ Other

**Leave Medical Message** ☐ Home Phone: ☐ Brief ☐ Extended ☐ Cell Phone: ☐ Brief ☐ Extended

**Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White ☐ Multiple ☐ Other Race ☐ Other Pacific Islander ☐ Refuse to Report

**Ethnicity:** ☐ Non-Hispanic ☐ Hispanic ☐ Refuse to Report **Primary Facility Location:** ☐ Conway ☐ Johnsonville ☐ Marion

**Preferred Language:** ☐ English ☐ Spanish ☐ Other: _____

**Translator Required**: ☐ Spanish ☐ Hearing Impaired **Use Street Address for Prescription:** ☐ **Veteran:** ☐ Yes ☐ No

**Homeless:** ☐ Yes ☐No **If yes:** ☐ Homeless Shelter ☐ Doubling Up ☐ Transitional ☐ Street ☐ Other ☐Unknown

**Public housing:** ☐ Yes ☐No

**Seasonal worker:** ☐ Yes ☐No **Migrant worker:** ☐ Yes ☐No **Dependent Status:** ☐Dependent of Migrant Worker ☐ Dependent of Seasonal Worker

**Gender Identity:** ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Chose not to disclose

**Sexual Orientation:** ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Something else ☐ Don't know ☐ Chose not to disclose

**How did you hear about us:** ☐ Billboard ☐ Family/ Friend ☐ Hospital ☐ Magazine ☐ Newspaper ☐ Other ☐ Radio ☐ Other Physicians Practice ☐ Phone book ☐ Television ☐ Online/ Website ☐ Outreach ☐ Social Media

**I hereby certify that the income circled 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 (# in household)_____**

| | | | |
|---|---|---|---|
| □ 0,000 - $12,060 | □ $32,960 - $37,139 | □ $43,837 - $48,062 | □ $69,004- $74,279 |
| □ $12,060 - $16,039 | □ $37,140 - $41,319 | □ $48,063 - $54,955 | □ $74,280- $82,639 |
| □ $16,040 - $20,140 | □ $28,780 - $32,959 | □ $54,956- $57,559 | □ $82,640- Above |
| □ $20,140 – $24,119 | □ $32,960 – $34,100 | □ $57,560 - $62,023 | |
| □ $24,120 - $27,158 | □ $34,101 - $38,276 | □ $62,024 - $65,919 | |
| □ $27,159 - $32,959 | □ $38,277 - $43,836 | □ $65,920 - $69,003 | |

01/17/18