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 UPDATE

MRN:__________ DATE:__________________

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:________

Additional Information: Email:_____________________________________ ☐ Does not have ☐ Will not disclose ☐ Other

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

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

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 **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

Insurance Change: **Currently on Sliding Fee Scale?** ☐ Yes ☐ No Level:______
Primary Insurance: ______________________________
Policy #:________________________Group #_________________________Subscriber's Birth date:_______________

Subscriber's Employer:_________________________________Subscriber's Social Security Number:________________

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