HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway St.
Johnsonville, SC 29555
843-386-3573 Fax: 877-322-0181

243 Singleton Ridge Rd.
Conway, SC 29526
843-248-4700 Fax: 877-322-0181

1608 N. Main St.
Conway, SC 29526
843-248-4700 Fax: 877-322-0181

145 Palmetto Pointe Rd.
Marion, SC 29571
843-423-2400 Fax: 877-322-0181

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:_____

For federal grant reporting purposes, we collect your household size and income levels to screen each person to see if you may be eligible for a discount on the amount you may owe for each visit or service.

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	