# 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

Chart #: _____

Patient Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

SS#: _____ DOB: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

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

Email Address: _____ ❑ Register for patient portal

Sex At Birth: ❑ Male ❑ Female

Gender Identity: ❑ Male ❑ Female ❑ Other ❑ Choose Not To Disclose
❑ Transmasculine / Female To Male ❑ Transfeminine / Male To Female

Sexual Orientation: ❑ Straight or Heterosexual ❑ Lesbian or Gay ❑ Bisexual or Pansexual
❑ Don't Know ❑ Other ❑ Chose Not To Disclose

Race: ❑ American Indian or Alaska Native ❑ Black or African America ❑ White ❑ Asian
❑ Native Hawaiian ❑ Multiple ❑ Other Race ❑ Other Pacific Islander ❑ Chose Not To Disclose

Ethnicity: ❑ Non-Hispanic ❑ Hispanic ❑ Refuse to Report

Preferred Language: ❑ English ❑ Spanish Other: _____ Translator Required? ❑ Yes ❑ No

Housing: ❑ Home Owner or Renter ❑ Public Housing
❑ Homeless ❑ Other: _____

If Homeless: ❑ Homeless Shelter ❑ Doubling Up ❑ Transitional
❑ Street ❑ Other ❑ Unknown

Seasonal Worker: ❑ Yes ❑ No

Migrant Worker: ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
❑ Single ❑ Partner ❑ Legally Separated

Student Status: ❑ Full Time ❑ Part Time ❑ Not A Student

Veteran ❑ Yes ❑ No

Employment Status: ❑ Full Time ❑ Part Time ❑ Not Employed ❑ Self Employed
❑ Retired ❑ Unknown ❑ Active Duty Military

Employer Name: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

Preferred Reminders: ❑ Call Home ❑ Call Work ❑ Call Cell ❑ Text Message
❑ Patient Portal ❑ Opt Out Of All Communications

Type of Reminders: ❑ Appointment ❑ Lab Results ❑ Preventative Health ❑ General Notifications

Preferred Time To Call: ❑ Morning ❑ Afternoon ❑ Evening

Leave Medical Message: ❑ Home ❑ Cell ❑ Brief ❑ Detailed

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 info 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: _____ DOB: _____

Relation to patient: _____ Email: _____ HIPAA ❑

Name: _____ Phone: _____ DOB: _____

Relation to patient: _____ Email: _____ HIPAA ❑

Emergency Contact: _____ Relationship to patient: _____

Do we have permission to share medical information with the emergency contact? ❑ Yes ❑ No

Phone: _____ Date of birth: _____ Email: _____

If under the age of 18, please provide parent-guardian name(s): _____

*If you have insurance of any kind, please present your card(s) at the front desk for billing and lab purposes.*

Primary Insurance: _____ Policy Holder: _____

Currently on sliding scale? ❑ Yes ❑ No Policy #: _____ Group #: _____

Relationship to patient: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ SSN#: _____

Secondary Insurance: _____ Policy Holder: _____

Relation to Patient: _____ Policy #: _____ Group #: _____

Employer: _____ SSN#: _____

Primary Location: ❑ Conway ❑ Johnsonville ❑ Singleton Ridge ❑ Marion

How Did You Hear About Us? ❑ Billboard ❑ Family/Friend ❑ Hospital ❑ Social Media
❑ Radio ❑ Online/Website ❑ Community Event ❑ TV
❑ Other Physicians Practice

Family Size (# in household): _____

Amount of income received: Weekly:_____ Monthly:_____ Yearly:_____

*PLEASE NOTE: Payment is required at time of service for all copayments, deductibles, and coinsurance, as dictated by your insurance company or sliding scale schedule. If needed, please make payments arrangement prior to your visit.*

*I understand that my medical information is confidential, but I authorize its release to my insurance companies, or as required by law.*

Signature: _____ Date: _____