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

6874 Hwy 908
Gresham, SC 29546
843-352-8772
Fax: 877-322-0181

1606 B Main St.
Conway, SC 29526
843-488-6350
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 ❑ Choose Not To Disclose

Race: ❑ American Indian or Alaska Native ❑ Black or African America ❑ White ❑ More Than One Race
❑ Asian: _____ ❑ Pacific Islander: _____ ❑ Choose Not To Disclose

Ethnicity: ❑ Mexican, Mexican American, Chicano ❑ Cuban ❑ Puerto Rican
❑ Another Hispanic, Latino, or Spanish Origin ❑ Not Hispanic, Latino, or Spanish Origin
❑ Unreported/ Choose Not To Disclose

Preferred Language: ❑ English ❑ Spanish ❑ Other: _____

Translator Required? ❑ 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 ❑ Self Employed ❑ Retired ❑ Active Duty Military
❑ Not Employed

Employer Name: _____ Employer Phone: _____

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

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

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

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

Preferred Time To Call: ❑ Morning ❑ Afternoon ❑ Evening

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

Emergency Contact: _____ Relationship to patient: _____

Do we have permission to share medical/psychiatric 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: _____

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

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 ❑ Marion ❑ Johnsonville ❑ Singleton Ridge ❑ Brittons Neck

How Did You Hear About Us? ❑ Billboard ❑ Community Event ❑ Family/Friend:_____
❑ Radio/TV ❑ Online/Social Media
❑ Other:_____

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: _____

Staff Name: _____