HEALTH CARE PARTNERS OF SC, INC.

843-248-4700 Fax: 877-322-0181

Patient Registration Chart #_____

Patient Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

SS #: _____ **DOB:** _____ **Age:** _____ **Sex:** _____

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

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

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Email Address:** _____

☐ ***Register for Patient Portal***

Preferred Pharmacy

☐ **HCPSC Pharmacy Conway** ☐ **HCPSC Pharmacy Marion** ☐ **HCPSC Pharmacy Johnsonville**

☐ **Other:** _____ **Address:** _____ **Phone Number:** _____

Responsible Party: ☐ **Self** ☐ **If under the age of 18, please provide parent-guardian name(s)** _____

DOB: _____ **Phone #:** _____ **Email address:** _____

Emergency Contact 1: _____ **Relation to patient:** _____ **Phone #:** _____

Do we have permission to share medical/psychiatric information with the emergency contact? ☐ **Yes** ☐ **No**

Emergency Contact 2: _____ **Relation to patient:** _____ **Phone #:** _____

Do we have permission to share medical/psychiatric information with the emergency contact? ☐ **Yes** ☐ **No**

Communication Method: ☐ **Call Home** ☐ **Call Cell** ☐ **Call Work** ☐ **Text Message** ☐ **Patient Portal**

Type of Reminders: Notifications ☐ **Appointments** ☐ **Lab Results** ☐ **Health Reminders** ☐ **Medication** ☐ **General**

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

Can we leave detailed personal health information on your voice message? ☐ **Yes** ☐ **No** ☐ **Home** ☐ **Cell**

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

Primary Insurance: _____ **Insured's Name:** _____

Policy #: _____ **Group #:** _____ **Patient relationship to Insured:** _____ **DOB:** _____

Employer Name: _____ **Employer Phone:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Secondary Insurance: _____ **Insured's Name:** _____

Member ID: _____ **Group #:** _____ **Patient relationship to Insured:** _____ **DOB:** _____

Housing: ☐ Homeowner or Renter ☐ Public Housing ☐ Homeless ☐ Other: _____

If Homeless: ☐ Homeless shelter ☐ Doubling Up ☐ Transitional ☐ Street ☐ Other

In the past 2 years, have you or a member of your family worked in agriculture on a seasonal basis? ☐ Yes ☐ No

Have you or your family established a temporary home to work in agriculture? ☐ Yes ☐ No

Have you ever served in the US military? ☐ Yes ☐ No

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

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

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ More than One Race

☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian

☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan

Ethnicity: ☐ Not Hispanic, Latino/a, or Spanish Origin ☐ Mexican, Mexican American, Chicano/a

☐ Cuban ☐ Puerto Rican ☐ Other Hispanic, Latino/a, or Spanish Origin ☐ Choose Not To disclose

Employment Status: ☐ Full time ☐ Part-time ☐ Self Employed ☐ Retired ☐ Active-Duty Military ☐ Not Employed

Student Status: ☐ Full time ☐ Part-time ☐ Not A Student

Please note: Payment is required at the time of service for all copayments, deductibles, and coinsurance, as dictated by your insurance company or sliding scale schedule. If needed, please make payment 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.

Patient/Guardian Signature: _____ **Date:**_____

How Did You Hear About Us? ☐ Billboard ☐ Community Event ☐ Family/Friend ☐ Radio/TV

☐ Online/Social Media ☐ Other: _____

Family Size (# of people in household): _____ **Currently on Sliding fee:** ☐ Yes ☐ No

Amount of income received: **Weekly:** _____ **Monthly:** _____ **Annually:** _____

FOR OFFICE USE ONLY

Staff Name: _____

Please print

Revised 02/13/2025

HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway St.
Johnsonville, SC 29555
843-386-3573
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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

PATIENT TREATMENT AUTHORIZATION FORM

Printed Patient Name: _____ Patient DOB: _____

I _____ hereby authorize the administration of medical/dental treatment(s) and the performance of medical/dental procedure(s) while _____ (Patient's Name) is a patient at Health Care Partners of SC, Inc.

I understand that such treatment(s) and procedure(s) will be performed by physicians, certified nurse-midwives, nurse practitioners, behavioral health practitioners, optometrists, dentist and/or dental hygienists and/or nurses and employees of Health Care Partners of SC, Inc. The intention hereof is to grant full authority to such physicians, certified nurse-midwives, nurse practitioners, behavioral health practitioners, and their respective assistants to administer and preform all drugs, treatments, test, or diagnostic procedures including the testing for infectious diseases such as, but not limited to Syphilis, Hepatitis B, and AIDS/HIV. I further consent to the testing for drugs if deemed advisable by or necessary in the professional judgment of physician, certified nurse-midwives, nurse practitioners, or dentist. Physicians, certified nurse-midwives, nurse practitioners and case managers for Health Care Partners of SC, Inc. have my permission to reveal information to appropriate agencies and individuals where it becomes necessary to protect the welfare of myself, the patient, and/or the community. I consent to and authorize the above mentioned for or upon me, or the person for whom I am authorized to consent.

Health Care Partners of SC, Inc. is authorized to furnish information or excerpts to another physician or provider, if any, and to any insurance company or authorized third party payer for the purpose of obtaining payment of the account of Health Care Partners of SC, Inc. for the services provided to the patient. I expressly agree to be personally responsible for any portion of the amount that is not paid by a third-party payer.

In addition to the above sources, I hereby give Health Care Partners of SC, Inc. permission to disclose or receive information to or from the following individuals.

NAME	RELATIONSHIP TO PATIENT

I hereby certify that I have read and understand the above authorization and that inappropriate paragraphs/sections, if any, were stricken and initialed by me before I affixed my signature and that no guarantees or assurances have been made as to the results of treatments and procedures(s)

_____ _____
Signature of Patient or Patient's Representative/Parent/Legal Guardian — Date

_____ _____
Printed Patient Name — Relationship to Patient

_____ _____
Witnessed by — Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

MRN_____

Printed Patient Name: _____ Patient DOB:_____

I hereby acknowledge that I have been offered or have received the HIPAA Notice of Privacy Practices document.

_____ Date: _____
Signature of Patient or Patient's Representative/Parent/Legal Guardian

_____
Signature of Patient or Patient's Representative/Parent/Legal Guardian

_____
Relationship to patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.
_____ Communications barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement.
_____ Other (Please Specify).

_____
_____
_____
_____
_____
_____

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PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION

Print Patient's Full Name:	Patient's Date of Birth:
Patient's Email Address:	Telephone:
Patient's Address:	

I give Health Care Partners of SC permission to discuss protected health information and to release test results to the following person(s):

To include information related to *(must circle)*: Substance Abuse Mental Health HIV/STD Birth Control/Reproductive Health Labs/Genetic Testing

Name:	Telephone:	Relationship:	DOB:
Name:	Telephone:	Relationship:	DOB:
Name:	Telephone:	Relationship:	DOB:

I give Health Care Partners of SC permission to leave protected health information on an answering machine or voicemail.

☐ Yes	☐ No	Telephone Number:

Would you like to sign up for the patient portal? ☐ **Yes** ☐ **No**

The patient portal allows you to get updates relating to your health quicker. You can also submit any questions or concerns directly to your provider or nurse without having to leave a voice message!

By signing this form, I give Health Care Partners of SC permission to send my medical information to the address provided.

Indicate your relationship to the patient: ☐ **Patient** ☐ **Authorized Representative**

_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

_____ _____

PRINT NAME *(if you are <u>not</u> the patient)* **DATE**

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ADULT HEALTH HISTORY

Patient Name: _____ **DOB:** _____ **Chart #:** _____

Please list any medications that you take daily:

Medication Name	Strength	How often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Please list any allergies with reactions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Please list any surgeries you have had:

Name of Surgery	Date of Surgery
1.	
2.	
3.	
4.	
5.	

Date of Last Hospitalization:

_____

Reason: _____

_____

_____

Please list the date of your last:

Colonoscopy: _____

Eye Exam: _____

Dental Exam: _____

Physical Exam: _____

Women ONLY

Mammogram: _____

Pap smear: _____

Was it abnormal? ☐ Yes ☐ No

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____

Do you have a Menstrual Cycle? ☐ Yes ☐ No

Select any that apply: ☐ Menopause ☐ Hysterectomy

Do you intend to become pregnant in the next year? ☐ Yes ☐ No

Social History/Health Habits/Safety:

Tobacco: ☐ Yes ☐ No **How often?** _____

Alcohol: ☐ Yes ☐ No **How often?** _____

Caffeine: ☐ Yes ☐ No **How often?** _____

Drugs: ☐ Yes ☐ No **How often?** _____

Do you workout/exercise? ☐ Yes ☐ No

Do you wear a seatbelt? ☐ Yes ☐ No

Do you use sunscreen? ☐ Yes ☐ No

What is your stress level at home? ☐ Low ☐ Medium ☐ High

Do you feel safe in your home? ☐ Yes ☐ No

Are you a victim of Domestic Violence? ☐ Yes ☐ No

Are you a victim of Human Trafficking? ☐ Yes ☐ No

Advance Directive (if yes, please leave a copy with the front desk):

Do you have a living will? ☐ **Yes** ☐ **No** **Power of Attorney?** ☐ **Yes** ☐ **No**

Please check and list any medical conditions you or your family currently have or has had in the past (Self, Brother, Mother, etc.):

☐ **Alcoholism/Drug Abuse:** _____
☐ **Birth Defects:** _____
☐ **Cancer/Tumor:** _____
☐ **Diabetes (Sugar):** _____
☐ **Heart Disease:** _____
☐ **High Blood Pressure:** _____
☐ **Asthma:** _____
☐ **High Cholesterol:** _____
☐ **Diabetes:** _____
☐ **Seizures:** _____
☐ **Heart Attack:** _____
☐ **Hearing Loss:** _____
☐ **Other:** _____

Dental History:

Have you had any periodontal (gum) treatments? ☐ **Yes** ☐ **No**
Do you wear dentures/partials? ☐ **Yes** ☐ **No**
Have you ever had any reactions to local anesthesia? ☐ **Yes** ☐ **No**
Do you have sleep apnea? ☐ **Yes** ☐ **No**
Have you ever had complications after an extraction? ☐ **Yes** ☐ **No**
Do you grind your teeth? ☐ **Yes** ☐ **No**
Do your gums bleed when you brush or floss? ☐ **Yes** ☐ **No**
Do you have sores/ulcers in your mouth? ☐ **Yes** ☐ **No**
Do you drink bottled or filtered water? ☐ **Yes** ☐ **No**
Is there fluoride in your home water? ☐ **Yes** ☐ **No**
Have you had problems with previous dental treatment? ☐ **Yes** ☐ **No**
Is your mouth dry? ☐ **Yes** ☐ **No**
Are you currently experiencing dental pain or discomfort? ☐ **Yes** ☐ **No**
Are your teeth sensitive to: ☐ **Hot** ☐ **Cold** ☐ **Sweets** ☐ **Pressure**

Are there any other medical conditions you or your family have that we need to be aware of?

_____
_____
_____
_____
_____

Health Care Partners of South Carolina

Thank you for trusting Health Care Partners with your medical care needs!

The mission of Health Care Partners of SC is to provide quality, affordable primary, preventative and supporting health care services, delivered with compassion, dignity, and respect.

Business Hours & Locations

Our Marion, Johnsonville, and Singleton Ridge offices are open Monday – Friday, 8:00am – 5:00pm. Our Conway location is open 8:00am – 6:00pm on Monday and 8:00am – 5:00pm Tuesday – Friday. Our Britton's Neck office is open Tuesday, Thursday, and Friday 8:00am – 5:00pm and closed on Monday and Wednesday. We operate on an appointment basis and offer same day appointments for acute illness. We also have a provider on call for any after-hours needs. If you have an emergency, please dial 911 or go to your nearest emergency room.

Appointment Scheduling

We will try to schedule your appointment on a date and time most convenient for you. As a courtesy, we attempt to contact every patient to remind them of their appointment. Please plan to arrive at least 15 minutes prior to your appointment and bring your medications, insurance information, and photo ID. New patients will need to arrive with completed paperwork, or 30 minutes early to complete the new patient paperwork. If you are unable to make your appointment, please contact our office at (843) 248-4700 to cancel as soon as possible as this allows us to better serve you and our other patients.

Patient Portal

We offer a free self-service health management tool that allows 24/7 access to communicate with your provider, view your appointments, view your medications, request refills, and view lab result access. To request access to our patient portal, kindly ask our front desk staff.

Pharmacy

Health Care Partners offers on-site pharmacy services at three of our locations: Conway, Marion, and Johnsonville. Kindly note that prescription *refills* may take up to 72 hours to be prepared and ready for pickup. Pharmacy hours are Monday –Friday, 8:30 am – 5:30 pm. Our pharmacy offers hundreds of prescription medications at discounted rates.

Services

Health Care Partners offers a wide variety of services to fit your medical needs and concerns. Services include Family Medicine, Pediatrics, Women's Health/OBGYN, Dental, Optometry, Behavioral Health, Substance Abuse Disorder Treatment, Pharmacy, Laboratory, Diabetes Prevention and Education Program, Vaccines, and Transportation.

Best Chance

Best Chance is a program that provides at no cost, breast, and cervical cancer screenings to South Carolina women ages 21 to 64 who qualify. Services included: breast exam, mammogram, pap smear, and pelvic exam. For more information about eligibility requirements, kindly ask our front desk staff.

Financial

Health Care Partners offers healthcare to all regardless of insurance status. Health Care Partners accepts most forms of insurance and offers financial assistance programs. To apply for our Sliding Fee Program, you will need to complete the application, provide picture ID with date of birth, proof of residency, proof of household income and household size. Verification of income is necessary once a year and anytime there is a change in your income.

"If you have experienced a new financial hardship (job loss, loss of housing, flood, fire, etc.) in the last six months, please call our office at 843-248-4700 and select the option for "Billing" to apply for assistance with your bill."

Scan here for more information about our Locations!

Call Us!
(843) 248-4700

Stay Connected!

Need help applying for health insurance coverage?

Local Navigators are available statewide.

to help you complete applications for health coverage, complete enrollment, and understand your new coverage. Navigators are knowledgeable in eligibility, enrollment and program specifications.

Their services are available to you at no cost.

Visit us: Health Care Partners of South Carolina

or call: 843-248-4700 ext. 5510 or 843-907-1607

for help with the Health Insurance Marketplace.

SOUTH CAROLINA PRIMARY HEALTH CARE ASSOCIATION

To find local help from a Navigator, visit
GetCoveredAmerica.org

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