



Patient

Chart # _____

Patient Name: _____

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 Reminder 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

Insurance

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/Representative/Parent/Legal Guardian: _____ Date: _____

How Did You Hear About Us? Website Direct Mail Drove by Center Existing Patient/Family
 Google Social Media Billboard Community Outreach Event

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 03/17/2026



Health Care Partners
OF SOUTH CAROLINA

Patient Treatment Authorization Form

Phone 843-248-4700 | Fax 877-322-0181

Printed Patient Name: _____ Patient DOB: _____

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

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 perform 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



Health Care Partners
OF SOUTH CAROLINA

Permission to Release Protected Health Information

Phone 843-248-4700 | Fax 877-322-0181

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.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Telephone Number:
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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

Patient/Representative/Parent/Legal Guardian

Print Name (*if you are not the patient*)

Date

Revised 03/06/2026



Health Care Partners
OF SOUTH CAROLINA

Acknowledgement of Receipt of Notice of Privacy Practices

Phone 843-248-4700 | Fax 877-322-0181



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 HIPPA Notice of Privacy Practices document.

Patient/Representative/Parent/Legal Guardian

Date

Patient/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 the acknowledgement.
- Other (Please Specify).



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: _____
- Cancer/Tumor: _____
- Heart Disease: _____
- Asthma: _____
- Diabetes: _____
- Heart Attack: _____
- Other: _____

- Birth Defects: _____
- Diabetes (Sugar): _____
- High Blood Pressure: _____
- High Cholesterol: _____
- Seizures: _____
- Hearing Loss: _____

Dental History:

Have you had any periodontal (gum) treatments? Yes No

Have you ever had any reactions to local anesthesia? Yes No

Have you ever had complications after an extraction? Yes No

Do your gums bleed when you brush or floss? Yes No

Do you drink bottled or filtered water? Yes No

Have you had problems with previous dental treatment? Yes No

Are you currently experiencing dental pain or discomfort? Yes No

Are your teeth sensitive to: Hot Cold Sweets Pressure

Do you wear dentures/partials? Yes No

Do you have sleep apnea? Yes No

Do you grind your teeth? Yes No

Do you have sores/ulcers in your mouth? Yes No

Is there fluoride in your home water? Yes No

Is your mouth dry? Yes No

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