



PATIENT REGISTRATION

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

Health Care Partners
OF SOUTH CAROLINA

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

Martial 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

How Did You Hear About Us? Website Direct Mail Drove by Center Existing Patient/Family

Google Social Media Billboard Community Outreach Event

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: _____

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 treatment(s) and procedure(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

PATIENT TREATMENT OF A MINOR AUTHORIZATION FORM

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

Authorization to Consent for Treatment of a Minor When Legal Guardian and/or Parent(s) Unable to Accompany Minor Patient

Printed Patient Name: _____ Patient DOB: _____

I _____ parent/guardian of above named minor
(Legal guardian or authorized agent)

patient, do hereby authorize the below named individual(s) as my agent(s) to consent to any medical/dental/behavioral health evaluation and/or treatment, which may include, but is not limited to x-ray examination, surgery evaluation and/or treatment, diagnosis of care which is deemed advisable by, and is to be rendered under the supervision of, a licensed Dentist, Physician or Nurse Practitioner, or Behavioral Health specialist. It also give my permission for Health Care Partners of SC to import my prescription history from external sources.

Physicians, certified nurse-midwives, nurse practitioners, behavioral health specialists and case managers for Health Care Partners of SC, Inc. have my permission to reveal information to appropriate agencies and individuals. I further understand that I may receive pre-recorded messages about current best practices regarding the patient name listed above. These authorized individuals are adults (over 21 years of age) and possess sound judgement. This authorization includes, but is not limited to hospital admission, if such is deemed necessary by the physician or Nurse Practitioner. It is understood that this authorization is given to provide authority and power on the part of my agent(s) listed below to give specific consent to any and all such evaluation, diagnosis, office treatment, local anesthetic administration or surgical treatment(s), which the physician or Nurse Practitioner in the exercise of his/her best judgment, may deem advisable.

This authorization shall be effective from today (fill in date) _____, and will remain in effect until such time it is revoked in writing and delivered to Health Care Partners of SC, Inc.

Authorized Agents/Individuals:

NAME	RELATIONSHIP TO MINOR

Signature of parent, guardian, or other legal representative

Date

Witness

Date



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.

Representative/Parent/Legal Guardian

Date

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).



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

Signature of Patient or Authorized Representative

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

Date

Revised 03/17/2026



Patient Name: _____ DOB: _____ Chart #: _____

Child's Previous Physician: _____

Please list any medications that your child takes daily:

Medication Name	Strength	How often?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Please list any surgeries your child has had:

Name	Date
<input type="checkbox"/> Tubes in ears: _____	_____
<input type="checkbox"/> Tonsils/Adenoids: _____	_____
<input type="checkbox"/> Other: _____	_____

Please check any allergies your child has or has had in the past and explain the reaction:

- | | |
|---|--|
| <input type="checkbox"/> Penicillin: _____ | <input type="checkbox"/> Codeine: _____ |
| <input type="checkbox"/> Amoxicillin: _____ | <input type="checkbox"/> Latex: _____ |
| <input type="checkbox"/> Sulfa (Bactrim or Spetra): _____ | <input type="checkbox"/> Insect Sting: _____ |
| <input type="checkbox"/> Erythromycin: _____ | <input type="checkbox"/> Foods (list): _____ |
| <input type="checkbox"/> Cefacior (Ceclor): _____ | <input type="checkbox"/> Other(s): _____ |
| <input type="checkbox"/> Aspirin: _____ | _____ |

Birth History:

- Birth Weight: _____
 Inches: _____
 Delivery: Vaginal Cesarean
 Born on term? Yes No
 Did the baby have any problems after birth? Yes No
 If yes, please explain: Jaundice Turned Blue
 Seizures Infection Vomiting
 Trouble Breathing Constipation
 Other: _____

Social History:

- Grade in school: _____
 School Performance: Good Fair Poor
 Has your child had any learning problems? Yes No
 Has your child been absent more than 10 days a year? Yes No
 Extracurricular Activities: Sports Band Choir
 Youth Group Scout Other: _____
 Hours of TV/Video per day: 1 hr 2-3 hr 3-4 hr 5+ hr
 Marital Status of Parents: Married Divorced
 Separated Widowed Never Married

Mother's Pregnancy History:

- Did the mother drink alcohol during the pregnancy? Yes No
 Did the mother have any problems during or after labor? Yes No
 Did the mother have any problems during pregnancy? Yes No
 If yes, please explain: Bleeding Kidney Infection Edema Diabetes Hypertension Vaginal Infections
 Other: _____
 Did the mother smoke during her pregnancy? Yes No
 Did the mother take any medication during pregnancy? Yes No If yes, what kind? _____
 Did the mother take any other drugs during pregnancy? Yes No If yes, what kind? _____

Safety:

Sunscreen of SPF 15 or higher used? Yes No

Smoke detectors present in home? Yes No

Are guns in the home? Yes No

Child wears helmet when riding bike, skateboarding, or skating? Yes No

If the child is under 5 years old, do you have the number for poison control posted and Ipecac syrup? Yes No

Does someone in the home know how to perform the Heimlich maneuver in case of an emergency (choking)? Yes No

Hot water turned down to under 120°? Yes No

Does your child wear a seatbelt/car seat/booster? Yes No

Are guns in a secure place in the home? Yes No

Nutrition:

Does your child have a special diet? Yes No

Does your child have any eating problems? Yes No

Does your child eat from the 4 food groups? Yes No

Is your child in the WIC program? Yes No

Does your child eat paint chips or chew on

window seals? Yes No

Please check any medical conditions your child has or has had:

Asthma Hay Fever Eczema Kidney trouble Heart murmur Seizures High Cholesterol

Hearing loss Chicken Pox Pneumonia Speech problems Bedwetting Frequent headaches

Constipation Kidney or bladder infections Frequent ear infections SIDS Eye or vision problems

Frequent sore throats

Family Health:

Mother's Name: _____ Mother's age: _____ Living at home? Yes No

Mother's Occupation: _____

Father's Name: _____ Father's age: _____ Living at home? Yes No

Father's Occupation: _____

Number of Siblings: _____ Are the siblings' shots up to date: Yes No

Please check and list any medical conditions your child's FAMILY currently has or has had in the past (Brother, Mother, Etc.):

Alcoholism/Drug Abuse: _____

Cancer/Tumor: _____

Heart Disease: _____

Asthma: _____

Diabetes: _____

Heart Attack: _____

Birth Defects: _____

Diabetes (Sugar): _____

High Blood Pressure: _____

High Cholesterol: _____

Seizures: _____

Hearing Loss: _____

Dental History:

Has your child ever had complications after an extraction? Yes No

Does your child's gums bleed when they brush or floss? Yes No

Does your child drink bottled/filtered water? Yes No

Has there been problems with previous dental treatment? Yes No

Are they currently experiencing dental pain or discomfort? Yes No

Does your child grind their teeth? Yes No

Does your child have oral sores/ulcers? Yes No

Is there fluoride in your home water? Yes No

Is your child's mouth dry? Yes No

Teeth sensitivity to: Hot Cold Sweets Pressure

Are there any other medical conditions your child or their family has that we need to be aware of?
