Hemophilia Association of New Jersey
197 Route 18 South, Suite 206 North
East Brunswick, New Jersey 08816

Member Registration Form

The information you provide is strictly confidential and is only to provide more effective services to you. The information will not be released to any other group or individual without your written consent.

(PLEASE PRINT OR TYPE)
One application per family member

Date you completed this form _____ **Is person a minor?** YES NO

Name: _____ _____
(PERSON WITH BLEEDING DISORDER) (PERSON MAIL SHOULD BE ADDRESSED TO)

Address: _____
(STREET ADDRESS)

_____
(CITY, STATE, ZIP CODE) (COUNTY)

Home #: ( ) _____ Work #: ( ) _____

Cell #: ( ) _____ Email Address: _____

Date of Birth: _____ Blood Type: _____ Social Security # _____

Type of Bleeding Disorder: _____ Are there Inhibitors? _____

What level of severity? Mild ☐ Moderate ☐ Severe ☐

Do you use home care nursing and/or have factor delivered to your home? _____

If so, **name of Home Care Company?** _____

Current Doctor's Name and Address: _____

_____

Name and Address of hospital (Treatment Center) at which you are usually treated: _____

_____

Name of Social Worker at Hemophilia Treatment Center: _____

Name of Spouse (if applicable): _____

Father's Name: _____ Mother's Full Maiden Name: _____

(OVER)

(CONTINUED FROM PREVIOUS PAGE)

Name and Ages of Brothers and Sisters
(PLACE A CHECK NEXT TO SIBLINGS WHO ALSO HAVE A BLEEDING DISORDER):

_____ ☐ _____ ☐

_____ ☐ _____ ☐

Is the person being registered? (Check the box that applies)

Under 21 living with parents or guardian ☐ Under 21 not living with parents ☐
Over 21 living in parent's household ☐ Over 21 not living with parents ☐

What medical insurance coverage do you have?

Name of insurance? _____ ID# _____

What name is the insurance coverage under? _____

Relationship to person registering? _____ Do you have additional insurance? YES NO

If YES, please include insurance name and ID#: _____

Name additional insurance is under? _____ Relation? _____

Please specify your ethnicity (check box that applies)

Hipanic or Latino ☐ Not Hispanic or Latino ☐

Please specify your race (check box that applies)

American Indian or Alaska Native ☐ Asian ☐
Black or African American ☐ White ☐
Native Hawaiian or Other Pacific Islander ☐ I decline to identify my race or ethnicity ☐

Is the person being registered as (please circle one):

a Student Employed (Full Time/Part Time) Unemployed Retired Other

Name and address of school or employer: _____

_____

Occupation: _____

If person being registered is a minor, please list:

Father's employer: _____ Occupation: _____

Mother's employer: _____ Occupation: _____

What additional programs would you like to see at HANJ? _____

_____

ARE YOU INTERESTED IN SERVING ON A COMMITTEE OF HANJ? YES NO