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 OF TYPE)
One application per family member

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

Name: ______________________________
(Person with bleeding disorder)

Address: ______________________________
(Street Address)

____
(City, State, Zip code)

MAIL SHOULD BE ADDRESSED TO?

____
(Name)

____
(County)

Telephone numbers:
Home: (___)________________
Work: (___)________________
Cell: (___)________________

E-MAIL ADDRESS:
____

Date of Birth: ____________ Blood Type: ______ Social Security # ______________

Type of Bleeding Disorder: ________________ Are there Inhibitors? ____________

What level of severity are you? 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: ________________

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

______________________________ ___ ______________________________ ___
______________________________ ___ ______________________________ ___

(Over)

(Continued From Previous Page)

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? ____________________

Relation to person registering? ____________________

Do you have additional insurance? Yes ____ No _____

If Yes, Please include insurance name and ID#: ____________________
(Name of Insurance) (ID#)

Name additional insurance is under? ________________ Relation? ____________

Please specify your ethnicity: (check box that applies)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Please specify your race: (check box that applies)
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian of Other Pacific Islander
☐ White
I decline to identify my race and 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
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