

A birth parent of an adopted person may submit a Contact Preference document to the State Registrar indicating his or her preference regarding contact with the adopted individual. The birth parent may change his or her preference at any time by submitting a revised Contact Preference document to the State Registrar.

We need the following information in order to find and match your request with our existing files. If you fail to provide complete and accurate information, then we may be unable to accept and process your request.

NOTE: You must also complete and submit a Family History Information form, which includes medical, cultural and social history information, in order for your Contact Preference form to be accepted for filing.

ORIGINAL BIRTH CERTIFICATE INFORMATION

Please provide complete and accurate information. While the Department will diligently search its files for an adoption record that matches your request, it does not warrant, promise or guarantee that it will be able to locate an adoption record that matches the information you provide in your request.

CHILD'S INFORMATION

Child's FIRST Name on Child's Original Birth Certificate:

Child's MIDDLE Name on Child's Original Birth Certificate:

Child's LAST Name on Child's Original Birth Certificate:

Suffix:

Note: If you are unsure of the exact date of the child's birth, please enter your best estimate.

Child's Date of Birth: [] Actual [] Estimate

Sex: [] Male [] Female

Country of Birth:

State of Birth:

County of Birth:

Municipality of Birth:

MOTHER'S INFORMATION

Mother's FIRST Name on Child's Original Birth Certificate:

Mother's MIDDLE Name on Child's Original Birth Certificate:

Mother's LAST Name on Child's Original Birth Certificate:

Mother's Date of Birth:

FATHER'S INFORMATION

Father's FIRST Name on Child's Original Birth Certificate:

Father's MIDDLE Name on Child's Original Birth Certificate:

Father's LAST Name on Child's Original Birth Certificate:

Father's Date of Birth:



BIRTH PARENT INFORMATION

NOTE: *The birth parent information requested below is for processing purposes and will not be released to a requester if you wish to retain your privacy at this time.*

Birth Parent's Current First Name:

Birth Parent's Current Middle Name:

Birth Parent's Current Last Name:

Birth Parent's Date of Birth:

Birth Parent's Relationship to Child: Mother Father

Phone 1: Home Mobile Work

Phone 2: Home Mobile Work

Phone 3: Home Mobile Work

Email Address:

Mailing Address:

City: State: Zip:

The Contact Preference form is only an expression of the birth parent's wishes regarding contact with the adoptee. There is no law requiring the adoptee to follow the preference selected by the birth parent on the form.

BIRTH PARENT'S CONTACT PREFERENCE

State your preference about contact with the adopted child.

Note: Selection is required.

A. I WOULD LIKE TO BE CONTACTED DIRECTLY.

I have provided the required contact preference information and an updated Family History Information document and am submitting them to the State Registrar as set forth in this document. *(Complete required information on the previous page.)*

B. I WOULD PREFER TO BE CONTACTED ONLY THROUGH AN INTERMEDIARY.

I have provided the required contact preference information and an updated Family History Information document. I am submitting both to the State Registrar as set forth in this document. I have named the listed individual to act as an intermediary. *(Complete the following required information.)*

Name of Individual or Agency:

Mailing Address:

City: State: Zip:

Phone 1: Home Mobile Work

Phone 2: Home Mobile Work

Phone 3: Home Mobile Work

Email Address:

C. I WOULD PREFER TO NOT BE CONTACTED AT THIS TIME.

If I decide later that I would like to be contacted, I will submit a revised Contact Preference form to the State Registrar. While I do not wish to be contacted at this time, I have completed the Family History Information form and am submitting it to the State Registrar. Additionally, I understand that because I have indicated a no contact preference I must update the Family History Information form and submit it to the State Registrar every ten (10) years until I reach the age of forty (40) and every five (5) years thereafter.

By signing, I certify that I am the birth parent of the adoptee and, that, to the best of my knowledge, the information I am supplying is correct and accurate. I understand that if I falsely represent that I am the birth parent of the adoptee on this form, then I may be subject to penalties pursuant to N.J.S.A. 26:8-69.

Signature of Birth Parent:

Date:

ORIGINAL BIRTH CERTIFICATE INFORMATION

Please provide complete and accurate information. While the Department will diligently search its files for an adoption record that matches your request, it does not warrant, promise or guarantee that it will be able to locate an adoption record that matches the information you provide in your request.

CHILD'S INFORMATION

Child's FIRST Name on Child's Original Birth Certificate:

Child's MIDDLE Name on Child's Original Birth Certificate:

Child's LAST Name on Child's Original Birth Certificate:

Suffix:

Child's Date of Birth: [] Actual [] Estimate

Sex: [] Male [] Female

Country of Birth:

State of Birth:

County of Birth:

Municipality of Birth:

MOTHER'S INFORMATION

Mother's FIRST Name on Child's Original Birth Certificate:

Mother's MIDDLE Name on Child's Original Birth Certificate:

Mother's LAST Name on Child's Original Birth Certificate:

Mother's Date of Birth:

FATHER'S INFORMATION

Father's FIRST Name on Child's Original Birth Certificate:

Father's MIDDLE Name on Child's Original Birth Certificate:

Father's LAST Name on Child's Original Birth Certificate:

Father's Date of Birth:

BIRTH PARENT INFORMATION

NOTE: The birth parent information requested below is for processing purposes and will not be released to a requester if you wish to retain your privacy at this time.

Birth Parent's Current First Name:

Birth Parent's Current Middle Name:

Birth Parent's Current Last Name:

Birth Parent's Date of Birth:

Birth Parent's Relationship to Child: Mother Father

Phone 1: Home Mobile Work

Phone 2: Home Mobile Work

Phone 3: Home Mobile Work

Email Address:

Mailing Address:

City: State: Zip:

BIRTH PARENT DEMOGRAPHIC INFORMATION

Your Current Age: Eye Color: Blood Type:

Height (inches): Hair Color: Primary Language Spoken:

Weight (lbs.): Race: Nationality (Citizenship):

Religion: Skin Color:

Highest Level of Education: Ethnic Background:

Your Place of Birth:
 Country: State: City:

BIOLOGICAL INFORMATION ON DECEASED FAMILY MEMBERS

List your family members who have passed away, age at death, and cause of death:

Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>
Relationship*:	<input type="text"/>	Age at Death:	<input type="text"/>	Cause of Death:	<input type="text"/>

*Relationship choices: •Mother •Son •Maternal Grandmother •Paternal Grandmother •Sister •Aunt
 •Father •Daughter •Maternal Grandfather •Paternal Grandfather •Brother •Uncle
 •Other Biological Parent

MEDICAL HISTORY

For each of the medical conditions listed below, please check the appropriate column indicating whether you or any of your blood relatives (mother, father, sisters, brothers, grandparents, aunts, or uncles) or any other of your children have the condition(s) listed. Comments should include information on age of onset or diagnosis, treatments received or hospitalizations for condition, etc.

Note: All fields under this section are required.

HEART AND BLOOD VESSELS

Medical Condition	Response		Comments
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Congestive Heart Failure	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Atherosclerosis	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Hypertension (High Blood Pressure)	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Other Cardiovascular Problems	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

BRAIN AND NERVES

Medical Condition	Response		Comments
Cerebral Palsy	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Seizures, Convulsions or Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

LUNGS

Medical Condition	Response		Comments
Chronic Bronchitis	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Emphysema	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Asthma	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Hay Fever or Other Allergies; Food or Drug Allergies	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

KIDNEY

Medical Condition	Response		Comments
Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

MEDICAL HISTORY, CONTINUED

For each of the medical conditions listed below, please check the appropriate column indicating whether you or any of your blood relatives (mother, father, sisters, brothers, grandparents, aunts, or uncles) or any other of your children have the condition(s) listed. Comments should include information on age of onset or diagnosis, treatments received or hospitalizations for condition, etc.

Note: All fields under this section are required.

BLOOD DISORDER

Medical Condition

Response

Comments

Sickle Cell Anemia or Tay-Sachs Disease

No Yes (Self)
 Not Known Yes (Relative)

JOINTS / SKELETON

Medical Condition

Response

Comments

Scoliosis

No Yes (Self)
 Not Known Yes (Relative)

Any Other Malformations

No Yes (Self)
 Not Known Yes (Relative)

ENDOCRINE (GLANDS)

Medical Condition

Response

Comments

Thyroid Disorder

No Yes (Self)
 Not Known Yes (Relative)

Diabetes

No Yes (Self)
 Not Known Yes (Relative)

Other Hormonal Disorder

No Yes (Self)
 Not Known Yes (Relative)

PSYCHOSOCIAL

Medical Condition

Response

Comments

Schizophrenia, Bipolar Disorder, or Chronic Depression

No Yes (Self)
 Not Known Yes (Relative)

Alcoholism, Drug Addiction or Tobacco Use

No Yes (Self)
 Not Known Yes (Relative)

Anorexia or Bulimia

No Yes (Self)
 Not Known Yes (Relative)

Other Mental or Emotional Illnesses

No Yes (Self)
 Not Known Yes (Relative)

SKIN DISORDERS

Medical Condition

Response

Comments

Eczema or Other Skin Conditions

No Yes (Self)
 Not Known Yes (Relative)

DEVELOPMENTAL

Medical Condition

Response

Comments

Learning Disability

No Yes (Self)
 Not Known Yes (Relative)

Mental or Physical Development Deficiencies

No Yes (Self)
 Not Known Yes (Relative)

Autism Spectrum

No Yes (Self)
 Not Known Yes (Relative)

MEDICAL HISTORY, CONTINUED

For each of the medical conditions listed below, please check the appropriate column indicating whether you or any of your blood relatives (mother, father, sisters, brothers, grandparents, aunts, or uncles) or any other of your children have the condition(s) listed. Comments should include information on age of onset or diagnosis, treatments received or hospitalizations for condition, etc.

Note: All fields under this section are required.

NEUROLOGICAL

Medical Condition	Response		Comments
Blindness, Glaucoma or Other Visual Problems	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Deafness or Other Ear Problems	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Speech Problem	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Muscular Dystrophy	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

GENETIC

Medical Condition	Response		Comments
Club Foot, Cleft Lip or Palate	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Down's Syndrome	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

MOTOR DEFICIENCIES

Medical Condition	Response		Comments
Multiple Sclerosis	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Other Paralysis or Crippling Disorder	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

CANCER

Medical Condition	Response		Comments
Cancer (Breast, Ovarian, Cervical, Prostate, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Tumors	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Cystic Fibrosis	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	
Huntington's Disease	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

MEDICAL HISTORY, CONTINUED

For each of the medical conditions listed below, please check the appropriate column indicating whether you or any of your blood relatives (mother, father, sisters, brothers, grandparents, aunts, or uncles) or any other of your children have the condition(s) listed. Comments should include information on age of onset or diagnosis, treatments received or hospitalizations for condition, etc.

Note: All fields under this section are required.

OTHER CONDITIONS

Medical Condition	Response		Comments
Any Other Conditions You or Others in Your Family May Have	<input type="checkbox"/> No	<input type="checkbox"/> Yes (Self) <input type="checkbox"/> Yes (Relative)	

SOCIAL/CULTURAL BACKGROUND

Cultural Background	Response		Comments
Prescription Drugs Taken During Pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self)	
Non-Prescription Drugs Taken During Pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self)	
Alcohol Use During Pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self)	
Amphetamines or Barbiturates Used During Pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self)	
Are birth parents related to each other (other than by marriage)?	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self)	
Were there special circumstances surrounding conception, pregnancy or delivery?	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self)	
Can you provide information about the mother's reproductive life (for example, the age at first menses; age at menopause, miscarriages or fertility issues)?	<input type="checkbox"/> No <input type="checkbox"/> Not Known	<input type="checkbox"/> Yes (Self)	

Please provide any additional information related to the Medical / Social / Cultural History section:

By signing, I certify that I am the birth parent of the adoptee and, that, to the best of my knowledge, the information I am supplying is correct and accurate. I understand that if I falsely represent that I am the birth parent of the adoptee on this form, then I may be subject to penalties pursuant to N.J.S.A. 26:8-69.

Signature of Birth Parent: Date: