

Cosmetic  
&  
General Dentistry

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RUBINSTEIN  
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PATIENT REGISTRATION INFORMATION.

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YOUR FULL NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ RECOMMENDED BY \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

BUSINESS PHONE (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ EMAIL \_\_\_\_\_

CELL (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ CELL PHONE PROVIDER \_\_\_\_\_

SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ DENTAL INSURANCE CARRIER \_\_\_\_\_

INSURANCE No. \_\_\_\_\_ GROUP \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

PHONE (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ CELL (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_