**Clinique de Sante Communautaire de l'Eglise Chretienne des Cities**

Haiti Outreach Ministries/Mission Communautaire de l'Eglise Chretienne des Cites

**PATIENT DENTAL HEALTH RECORD**

**Nom De Famille:** _____ **Prenom**:_____ **Date De Naissance: (J/M/A)** _____

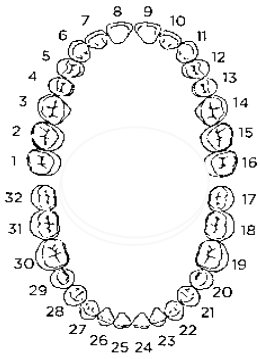
**Sexe: H/F L'Age:** _____ **Paran (pou timoun) oswa yon kontak ijans** _____ **Telefòn** _____
Parent (for children) or emergency contact

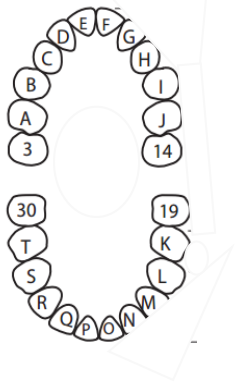
**Adresse:** _____ **Telefòn** _____

**Medical/Dental HX** *(Circle)* HTN DM Seizures Asthma Anemia GERD Other: _____

**Vaccinations:** TDap Hep A/B Polio MMR BHG **Medications:**

**DATE:** _____ **BP:**_____ **HR:**_____ **Resp:**_____ **Temp:** _____ **Weight:**_____ kg _____ lb




☐ **Retounen nan klinik** (Return to Clinic) **Date:** **Doktè** (Doctor)

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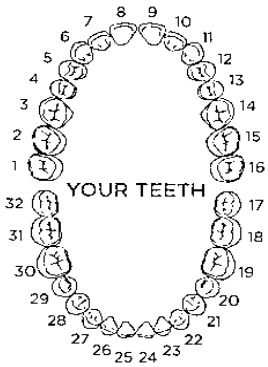
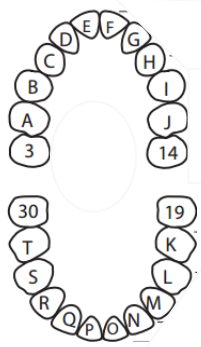
lb

**DATE:** _____ **BP:**_____ **HR:**_____ **Resp:**_____ **Temp:**_____ **Weight:**_____ kg _____

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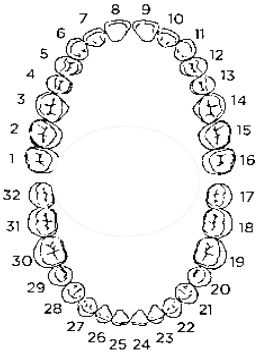


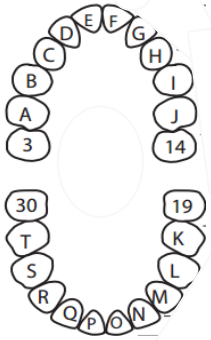


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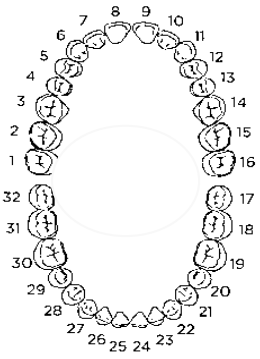


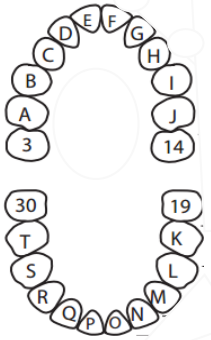


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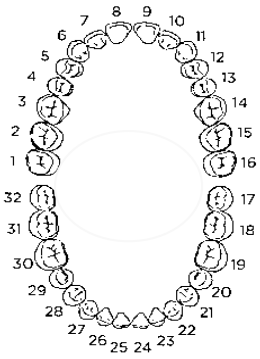


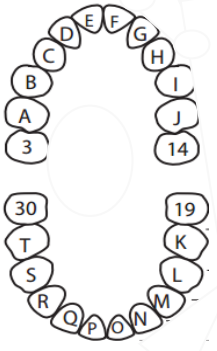


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