

☐ **Mulokozi K. Lugakingira, D.M.D., D.D.S., M.S.**

☐ **Franklin N. Awah, D.D.S., M.D.**

Fort Wayne

**ORAL MAXILLOFACIAL
SURGERY & IMPLANT CENTER**

2121 East Dupont Road, Suite C
Fort Wayne, Indiana 46825
(260) 490-2013 • (800) 240-0350
Fax (260) 490-1081
fortwayneoms@comcast.net

Introducing _____

E-mail _____

Seen by Dentist _____

Date _____

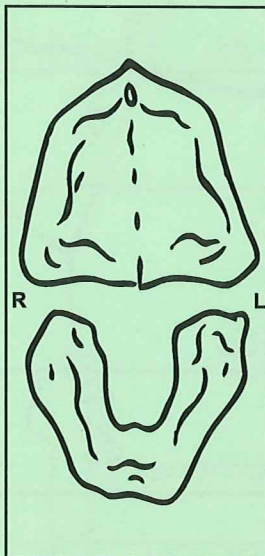
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

RIGHT LEFT

DECIDUOUS

DECIDUOUS

LOWER



DOB: _____

Appointment Date: _____

Appointment Time: _____

Remarks: _____

REMARKS _____

FROM DOCTOR _____ PHONE _____

****IF YOUR PATIENT HAS A HISTORY OF ENDOCARDITIS, ARTIFICIAL HEART VALVE OR ARTIFICIAL JOINTS, PREMEDICATION IS NECESSARY PRIOR TO APPOINTMENT, PLEASE CONTACT OUR OFFICE.**

****IF YOUR PATIENT HAS A HISTORY OF CARDIAC, DIABETES, HIGH BLOOD PRESSURE, OR OTHER SIGNIFICANT MEDICAL PROBLEMS, WE PREFER TO EVALUATE PATIENTS WITH A PRE-SURGICAL CONSULTATION.**

****PATIENTS WHO WILL BE HAVING I.V. SEDATION OR LOCAL ANESTHESIA ARE TO TAKE ALL OF THEIR MEDICATIONS AS USUAL WITH A SMALL SIP OF WATER.**

****IF YOUR PATIENT PLANS TO GO TO SLEEP FOR SURGERY AND DOES NOT PLAN TO HAVE A PRESURGICAL CONSULTATION, PLEASE REMIND THE PATIENT TO:**

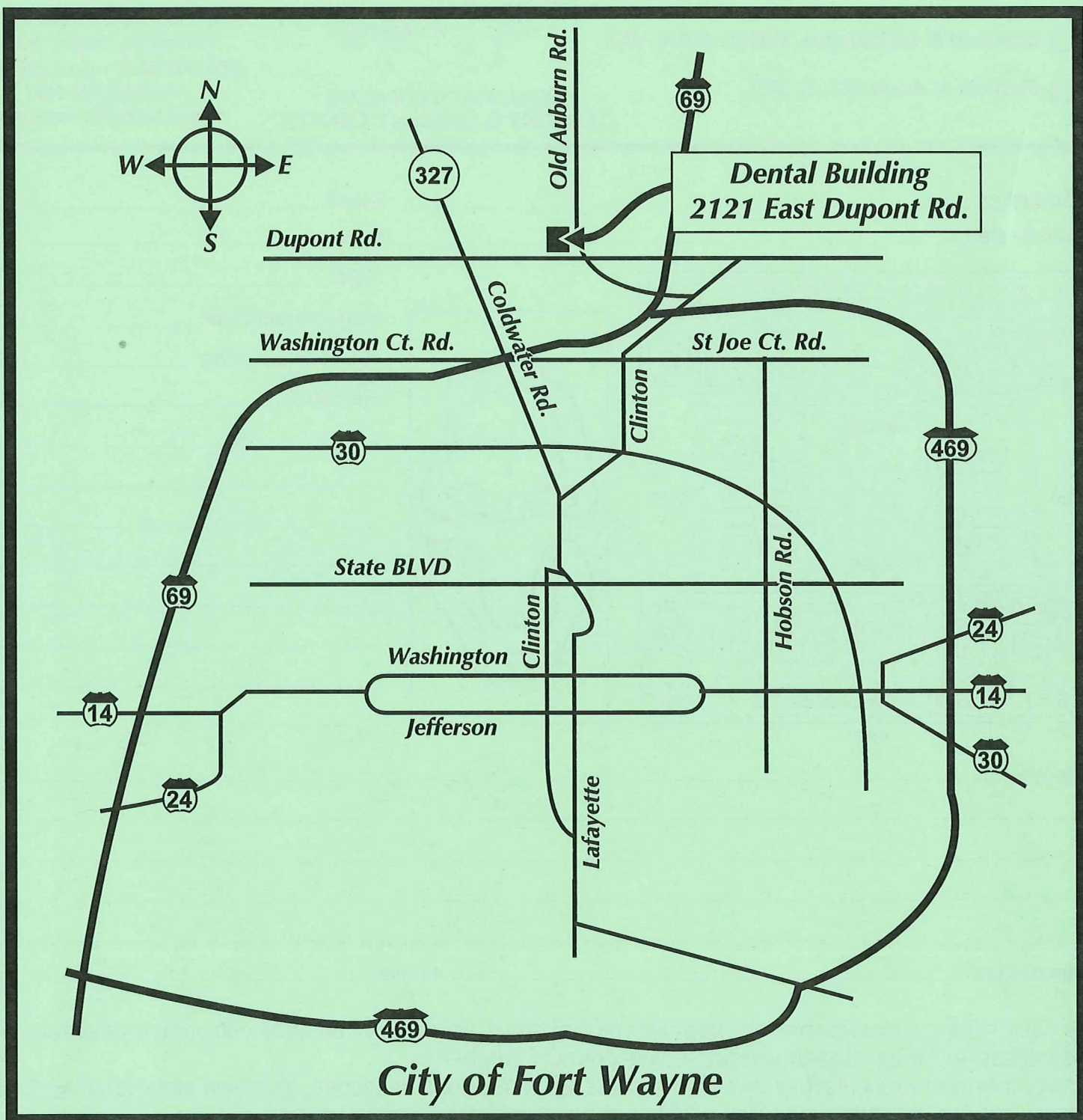
1. Have NOTHING to eat or drink after 12:00 midnight the night before surgery.
2. Bring someone WITH YOU on the day of surgery who will stay in the office during your surgery and drive home afterward
3. Wear loose, short-sleeved, comfortable clothes.
4. Have parental or legal Guardian's permission.

X-RAYS THAT ARE SENT TO OUR OFFICE WILL NOT BE RETURNED. PLEASE SEND A DUPLICATE FILM WITH YOUR REFERRAL.

IF YOU CHOOSE NOT TO SEND ONE, WE WILL BE HAPPY TO TAKE ONE AT THE TIME OF THE APPOINTMENT.

(NOTIFY OUR OFFICE 24 HOURS IN ADVANCE IF A COLD OR FEVER DEVELOPS.)

OVER



Fort Wayne

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*Practice limited to Oral and
Maxillofacial Surgery*

HOURS
Mon - Thur. 8 am - 4 pm
Fri. 8 am - 12 pm