

Dear New Patient,

We are delighted to welcome you to our practice and appreciate the trust you have placed in us by scheduling an appointment for an evaluation and consultation.

An accurate record of your past and current medical condition is vitally important. Please complete and mail or fax {(502) 245-1065} to us all the new patient forms from our website as soon as possible. Do not write extra information outside the lines on the questionnaires since we gather all needed information thoroughly during your interview. The patient information form must include the name of the doctor or dentist who has referred you. **New patients will be rescheduled if they have received new patient paperwork via our website, mail, or fax, but do not have it filled out beforehand or if they arrive 15 minutes later than their scheduled appointment time.**

Your appointment will take approximately **two and a half hours**. The fee for our complete diagnostic evaluation is \$216.00. Your insurance co-payment **or** payment in full for the diagnostic fee is required at your first visit. Any necessary imaging will be charged accordingly. If your insurance requires a referral, it is your responsibility to call your primary care physician to obtain the referral. Please have your PCP fax your referral to (502) 245-1065 prior to the appointment. If you have had a **sleep study**, bring those results with you or have them faxed to us before your appointment. Bring the results of any X-rays, CT scans, or MRI results that you have already had done for this problem. In order to obtain the most accurate exam results, patients shall abstain from pain medications the day of the exam. **Also, please bring any mouth guards or TMJ appliances that you may already have to this appointment.**

Our staff welcomes the opportunity to assist you in every way possible. We will call to remind you of your scheduled appointment two days in advance. **If we do not have verbal confirmation from you within 24 hours of your appointment, we will offer that time slot to another patient in need. Patients who do not show for their first appointment without calling to cancel or reschedule will not be scheduled again.** As a pain practice, we strive to work patients in as quickly as possible, and knowing whether a person intends to keep their appointment helps us achieve that goal. If you have any questions that need to be answered before your evaluation appointment, please call us. In the meantime, we look forward to meeting you and serving your needs.

Sincerely,
Alicia Rademaker
Patient Care Assistant

OFFICE DRUG POLICY

Our office drug policy limits the prescribing of narcotics and benzodiazepines. Narcotics include hydrocodone drugs like Lortab and Vicodin; drugs with codeine; and oxycodone drugs like Oxycontin, Percocet, and Tylox. The benzodiazepine drugs include Ativan, Fiorinal, Klonopin, Restoril, Valium, and Xanax. Drugs such as Soma, Talwin, or Ultram may also be contraindicated. This policy also applies to any other medications that may be potentially addictive or harmful.

TMD Questionnaire

Name: _____
Sex: M F Date of Birth: _____
Occupation: _____

Work Status:

- Working full-time
- Working part-time
- Disabled
- Unemployed
- Retired
- None of the above

Marital Status:

- Single
- Married
- Widowed
- Divorced
- Separated
- Cohabit

Number of Children: _____
Ages: _____

Number of persons living with you: _____
Number of family members with serious handicap:

Number of family members who have had
emotional or psychiatric problems:

Is there currently a question of lawsuit or disability
concerning your pain condition?
 Yes
 No

Highest level year of school you have completed:

Grade School:
0 1 2 3 4 5 6 7 8

High School:
9 10 11 12

College/Vocational School:
13 14 15 16

Graduate School

What problem brings you to our office?

How did you first experience this problem?

How long have you had this problem?
_____ Years _____ Months
_____ Weeks _____ Days

How often does this problem occur?

Do you have pain in relation to this problem?
 Yes
 No

If yes, what starts or worsens it?

What eases or reduces it?

Pain tends to be worse:
 In the morning
 During the day
 In the evening
 During the night

In the past month your pain has become:
 Less severe
 More severe
 Stayed the same

If there has been a change in the severity of your
pain in the last month, to what do you attribute
this change?

Check All That Apply:

Face/Jaw Pain:

- Left / Right / Both
- Stiff/Sore when waking up
- Chew mostly on one side
 - Left / Right
- Pain with chewing
- Oral habits or practices that aggravate or cause pain, such as chewing ice, chewing fingernails, biting pencils, etc.
- Have been in an accident or received a blow or injury to your face, head, jaw, or neck

Date: _____

Describe: _____

Jaw Sounds:

- Left / Right / Both
 - During early opening
 - While chewing
 - Moving jaw side to side
 - Wide opening
 - Popping/Clicking
 - Grating
 - Other: _____
- Sound always present
- Pain associated with sound

Jaw Locking:

- Has locked open
- Can close it yourself
 - Date of first occurrence: _____
 - How many times has it locked open? _____
- Has locked closed/partially closed
 - Longest time it has stayed locked: _____
 - Date of first occurrence: _____
 - How many times has it locked closed? _____
- When opening mouth, something in the jaw joint feels like it is in the way:
 - Left / Right / Both
- Need to move jaw side to side to open or close
- Opening has become limited
- Painful when locked closed
 - Which side(s):
 - Left / Right / Both
- Painful when locked open
 - Which side(s):
 - Left / Right / Both

Ear Problems:

- Left / Right / Both
- Pain
- Buzzing
- Ringing
- Stuffiness

Headaches:

- Wake up with a headache
- Headaches later in the day
- Frequency: _____
- Nausea or vomiting
- Vision changes
 - Describe: _____
 - _____
- Headache medication(s) past/present:
 - _____
 - _____
- Previous headache tests/treatments
- I find my headaches are relieved by:
 - Pain medication
 - Exercise
 - Rest
 - Sleep
 - Other: _____

Pain/Other:

- Neck
- Throat
- Eye
- Back Where: _____
- Dizziness or dizzy spells
- Muscle twitching
- Pain, numbness, or tingling in arms, hands, or fingers Where: _____

Teeth:

- Tooth/Teeth Problems
 - Pain / Sensitivity
- Have worn braces
 - When: _____
 - Reason: _____
- Chew gum
 - Never / Seldom / Often
- Clench or grind teeth
 - When under stress or tension
 - During sleep
 - Other: _____
- Grinding teeth causes or contributes to pain
- Mouth guard
 - Hard / Soft
 - Upper / Lower

Sleep:

- Often feel fatigued or tired
- Sleep poorly
- Awaken frequently during the night
- Restless sleeper
- Vivid dreams or nightmares
- Go to bed more tired than daily activities justify
- Do not feel rested upon waking
- Sleep Medication and/or OTC sleep aid:
 - Past: _____
 - Present: _____

Other:

- Presently, or ever been, under care of a psychiatrist or psychologist
When: _____
- Pain has made work impossible for you
- Constantly made miserable by poor health
- Have to lie down and rest due to pain
- All you can think about is your pain
- Unable to do things you want due to pain
- Doctors seem to have failed you
- Keep looking for a specialist to solve your case
- Have trouble getting doctors to take you seriously
- Have had some doctors say your pain is imaginary
- Secretly think your case might be hopeless

- Think that the pain is due to something different from or more serious than what doctors have been able to tell you thus far. If so, what?

- Presently have, or have had, other significant medical problems not mentioned. If so, what?

- Have had serious problems associated with previous dental treatment. If so, what?

- Have you ever had TMJ surgery?
If so, when? _____

- Rate your current occupational stress level:
Low ☺ 1 2 3 4 5 6 7 8 9 10 ☹ High
- Rate your current personal stress level:
Low ☺ 1 2 3 4 5 6 7 8 9 10 ☹ High

Have you experienced any of the following?

- Recent death of loved one
When? _____
- Family problems
When? _____
- Financial problems
When? _____
- Physical/sexual abuse
When? _____
- Job changes/problems
When? _____

- Do you have any disease, condition, or problem not listed above that you think I should know about?
Describe: _____

- Average intensity of my pain this week:
Low ☺ 1 2 3 4 5 6 7 8 9 10 ☹ High
- My pain at its worst:
Low ☺ 1 2 3 4 5 6 7 8 9 10 ☹ High
- My pain at its least:
Low ☺ 1 2 3 4 5 6 7 8 9 10 ☹ High



Patient Name _____ Date of Birth _____

Today's Date _____

HEADACHE QUESTIONNAIRE

Directions: Please circle yes to answer any questions that seem to pertain to your headaches. Skip the question if the answer is no.

1. Did this same headache ever occur before?	yes			
2. Do you have more than one type of headache?	yes			
3. Do your headaches usually occur during daytime hours?	yes			
4. Does your mother, father, siblings, children or any blood relative have similar headaches? (answer NA if adopted)	yes			
5. Do you have any changes in vision (flashing lights, blurred vision, or spots) before or during a headache?	yes			
6. Does your headache pain throb or pound?	yes			
7. Do your headaches occur during weekends and holidays?	yes			
8. Do alcoholic drinks cause or aggravate your headaches?	yes			
9. Does chocolate, cheese, milk, nuts, Chinese food, or any food cause or worsen your headache?	yes			
10. Have you noticed any paralysis, muscle weakness, numbness, swallowing problems or speech changes during your headaches?	yes			
11. Would you describe your headache as moderate to severe in intensity?	yes			
12. Does your headache ever require you to lie down?	yes			
13. Do you prefer a dark, quiet room when you have a headache?	yes			
14. Do you ever miss work (or school) because of a headache?	yes			
15. Do you see zigzag lines before a headache?	yes			
16. Does your headache last between 1 to 3 days?	yes			
17. Is your headache unresponsive to plain aspirin or Tylenol?	yes			
18. Do bright lights or sunshine cause your bad headaches?	yes			
19. Does a change in barometric pressure, or storms, ever trigger your headache?	yes			
20. Does a change in your sleep schedule trigger your headaches?	yes			
21. Does your headache pain feel as if your heart is beating in your head?	yes			
22. Did your headaches begin in adolescence or early adulthood?	yes			
23. Do you ever feel tired prior to a headache starting?	yes			
24. Do you ever have excessive thirst/hunger prior to a headache?	yes			
25. Do odors such as perfumes or gasoline fumes ever trigger a headache?	yes			

26. Do you feel drained or "worn-out" the day after a headache?	yes			
27. Did you ever suffer from motion sickness as a child?	yes			
28. Do you lose your appetite with a headache?	yes			
29. Do you ever feel lightheaded or off-balance with a headache?	yes			
30. Do you ever experience difficulty thinking or speaking clearly with a headache?	yes			
31. Do you ever have diarrhea after a headache?	yes			
32. Does constipation ever seem to trigger your headaches?	yes			
33. Is it difficult to read during a headache?	yes			
34. Will watching TV aggravate a headache?	yes			
35. Is your headache pain dull and steady, like an intense constant pressure?		yes		
36. Do you usually have more than 5 headaches per week?		yes		
37. Do your headaches usually occur during the night?			yes	
38. Do you have watering of the eye on the affected side of the headache?			yes	
39. Do you get multiple headaches, which wake you, during the night?			yes	
40. Would you describe your headache pain as a red-hot poker in one eye?			yes	
41. Would you describe your headaches as a squeezing or vise-like sensation?		yes		
42. Do you <u>always</u> have a headache (daily headache)?		yes		
43. Does coughing or sneezing ever <u>start</u> a headache?				yes
44. Do you tend to pace the floors with a headache?			yes	
45. Do you get several very intense headaches daily, each lasting less than 5 minutes?				yes
46. Are your headaches so excruciating that you have considered suicide?			yes	
47. Can you have 6-12 month periods when you experience NO headaches?			yes	
48. Is your headache less bothersome if you keep active at work or play?		yes		
49. Do your neck or shoulder muscles feel tight and painful during a headache?		yes		
50. Do you have frequent muscle and joint pain?		yes		
51. Have you been feeling down or depressed?		yes		
52. Have you noticed a decrease in your sexual desire or drive?		yes		
53. Do you often feel moody or easily irritated?		yes		
54. Have you noticed a general change/distortion in your perception of taste?				yes

National Headache Foundation
www.headaches.org

Name: _____ Age: _____ Sex: _____ Date: _____

The Epworth Sleepiness Scale																					
<p>How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, estimate how they would have affected you.</p> <p>Use the following scale to choose the most appropriate number for each situation.</p> <p>0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Situation</th> <th style="text-align: right; border-bottom: 1px solid black;">Chance of Dozing</th> </tr> </thead> <tbody> <tr><td>Sitting and reading</td><td style="text-align: right;">_____</td></tr> <tr><td>Watching TV</td><td style="text-align: right;">_____</td></tr> <tr><td>Sitting inactive in a public place (theater, etc.)</td><td style="text-align: right;">_____</td></tr> <tr><td>As a passenger in a car for an hour without a break</td><td style="text-align: right;">_____</td></tr> <tr><td>Lying down to rest in the afternoon when circumstances permit</td><td style="text-align: right;">_____</td></tr> <tr><td>Sitting and talking to someone</td><td style="text-align: right;">_____</td></tr> <tr><td>Sitting quietly after lunch without alcohol</td><td style="text-align: right;">_____</td></tr> <tr><td>In a car, while stopped for a few minutes in traffic</td><td style="text-align: right;">_____</td></tr> <tr><td>Total Score</td><td style="text-align: right;">_____</td></tr> </tbody> </table>	Situation	Chance of Dozing	Sitting and reading	_____	Watching TV	_____	Sitting inactive in a public place (theater, etc.)	_____	As a passenger in a car for an hour without a break	_____	Lying down to rest in the afternoon when circumstances permit	_____	Sitting and talking to someone	_____	Sitting quietly after lunch without alcohol	_____	In a car, while stopped for a few minutes in traffic	_____	Total Score	_____
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Behavior During Sleep															
<p>Use the following scale to choose the most appropriate number for each situation:</p> <p>0 = Never during a usual night 1 = Less often than once a week 2 = Once to about half the nights per week 3 = Half the nights to almost always 4 = Almost always or every night ? = Don't know or haven't been told</p>	<p>During your usual sleep, you have noticed or have been told you do the following:</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Snore loudly</td><td style="text-align: right;">_____</td></tr> <tr><td>Stop breathing</td><td style="text-align: right;">_____</td></tr> <tr><td>Choke, struggle for breath</td><td style="text-align: right;">_____</td></tr> <tr><td>Toss and turn frequently</td><td style="text-align: right;">_____</td></tr> <tr><td>Wake up with a headache</td><td style="text-align: right;">_____</td></tr> <tr><td>Usual number of hours of sleep per night</td><td style="text-align: right;">_____</td></tr> <tr><td>Number of times you rise to use the toilet</td><td style="text-align: right;">_____</td></tr> </tbody> </table>	Snore loudly	_____	Stop breathing	_____	Choke, struggle for breath	_____	Toss and turn frequently	_____	Wake up with a headache	_____	Usual number of hours of sleep per night	_____	Number of times you rise to use the toilet	_____
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Height _____ft _____inches Present body weight _____lbs. Weight gained in last 12 months _____lbs.

Have you had an overnight sleep test? Y / N If yes, indicate the date of the study and the results thereof.

Have you seen any doctors for snoring, and what did they advise or do?

Signature

Date

Patient Information

Date: _____ Social Security No.: _____

Patient's Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Occupation: _____

Gender: Male: Female: Referred By: _____

Responsible Party Information:

Name: _____ Birthdate: _____

Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer Name & Address: _____

Insurance Information:

Insured's Name: _____ ID#: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Insured's Phone: _____ Insured's Birthdate: _____

Insurance Company: _____ Group #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Do you have dual coverage? Yes: No: If yes, Insured's Name: _____

Insurance Company and Address: _____

Insured's Employer: _____ ID#: _____ Group#: _____

Emergency Contact:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Signature (Parent's signature, if patient is a minor): _____

7. Do you have, or have you had, any of the following diseases or problems?

Check all that apply.

Cardiovascular:

- Rheumatic fever/heart disease
- Congenital heart lesions
- Heart trouble
- Heart attack
- Coronary insufficiency
- Coronary occlusion
- High blood pressure
- Arteriosclerosis
- Stroke
- Pain in chest upon exertion
- Short of breath after mild exercise
- Ankles swell
- Shortness of breath when lying down, require extra pillows when sleeping
- Low blood pressure

Neurological:

- Stroke
- Fainting spells
- Epilepsy, seizures

Respiratory:

- Allergies
- Sinus trouble
- Asthma
- Hay fever
- Persistent cough
- Cough up blood
- Tuberculosis

Dermal/Musculoskeletal:

- Hives or skin rash
- Osteoarthritis
- Fibromyalgia

Diabetes:

- Urinate more than six times daily
- Thirsty much of the time
- Mouth frequently becomes dry

Gastrointestinal:

- Stomach ulcers
- Kidney trouble
- Tuberculosis
- Hepatitis, jaundice, or liver disease

Blood disorders:

- Abnormal bleeding associated with previous extractions, surgery, trauma
- Anemia
- Bruise easily
- Have ever required a blood transfusion

Explain: _____

Other

- Venereal disease
- HIV-positive/AIDS
- Cancer/Malignant tumor
- Radiation treatment
- Chemotherapy
- Surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips
- Serious trouble associated with previous dental treatment
- Employed in any situation which exposes you regularly to x-rays or other ionizing radiation
- Family history of rheumatoid arthritis
- Claustrophobia

Medications (Please list all below):

Allergic reactions or reacted adversely to:

- No known allergies
- Local anesthetics
- Penicillin or other antibiotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Iodine
- Codeine or other narcotics
- Other:

Do you have any disease, condition, or problem not listed above that you think I should know about?

Women:

- Possibility of pregnancy
- Problems associated with your menstrual period

Please list the names, phone numbers, addresses, and types of health care providers you have seen for your problem during the past year.

Name	Address	Phone	Type
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Please describe the treatment you have received for your pain:

When you use the following, how many do you have in a day?

Coffee: _____ cups/day	Tobacco: _____ cigarettes/day
Cola: _____ cups/day	Beer: _____ 12 oz. cans/day
Wine: _____ glasses/day	Liquor: _____ ounces/day

Do you think you drank beer, wine, or liquor in the past year because of your pain? YES NO

Do you think you used too much of any drug in the past year because of your pain? YES NO

Mark YES or NO for the following questions, whichever applies.

(Your answers are for our records only and are confidential.)

1. A change in your general health within the past year.....YES NO

If YES, what? _____

2. Date of last physical examination: _____

3. Currently under the care of a physician.....YES NO

4. Name and address of my physician is: _____

5. Have had any serious illness, accident, or operation.....YES NO

If YES, what? _____

6. Have been hospitalized or had a serious illness within the past 5 years.....YES NO

If YES, what was the problem? _____

Signature: _____ Date: _____

Financial Policy

Thank you for choosing our office for your medical needs. We make every effort to work with our patients to ensure affordable services.

We are participating providers with Anthem, Humana, and United Healthcare medical plans. The office will call your insurance company before your first visit to verify your benefits. The insurance information that we give you on your first visit is based solely on the information the office was given by your insurance company. It is only accurate if the insurance company provides correct benefits. The insurance company, not this office, ultimately decides what benefits will or will not be paid. You are responsible to pay your bill within 45 days after your insurance company has rejected the claim.

We also file Medicare and secondary insurance plans. The Medicare fee schedule is accepted on office visits and physical therapy. Medicare does not pay for orthotic devices. If it is recommended by the doctor that you have a TMJ splint, NTI therapy or an OSA sleep appliance, you will be expected to pay the full amount when you receive the appliance.

Tricare is accepted when a referral is received from your primary care provider and authorization is sent to this office. Tricare does require a co-payment on some services. You will be expected to pay any non-covered charges when you receive a statement.

If you are not in one of the health plans with which we are participating providers, you will be responsible to pay your bill in full or make financial arrangements with the office manager. As a courtesy to our patients, your insurance will be billed for you. The insurance company or this office will reimburse any amount paid.

All co-payments, deductibles and any charge not covered by your insurance should be paid at the time of service.

Care Credit is a means that you can use to finance any services not covered by your insurance carrier. Care Credit offers a twelve-month, interest-free plan. All financed services for periods over twelve months will require you to pay interest. The minimum amount financed is \$300.00.

The charge is \$216.00 for an office consultation. There may be an additional charge if x-rays or other imaging is needed, or if additional treatment services are needed. If you do not have insurance coverage with one of the health plans accepted by this office, the total amount is due at the time of service.

Signature: _____ Date: _____

Patient Record Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving correspondence with spouse or family member.

I wish to be contacted in the following manner (check all that apply):

Home telephone number: _____

- Leave a message with detailed information
- Leave a message with call back number only

Cell phone number: _____

- Leave a message with detailed information
- Leave a message with call back number only

Work telephone number: _____

- Leave a message with detailed information
- Leave a message with call back number only

Written Communication:

- Mail to my home address
- Mail to my work address
- Fax to this number: _____

The following person(s) are able to speak with the doctor or office staff regarding my treatment or billing questions:

<u>Name (First and Last)</u>	<u>Relationship to Patient</u>	<u>Phone Number(s)</u>
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This consent will remain in effect unless otherwise revoked in writing.

Patient/Guardian Signature

Date



Bryan H. Burdette, DMD, MS

13050 Magisterial Drive, Suite 100
Louisville, Kentucky 40223
Phone: (502) 245-1061
Fax: (502) 245-1065

Located in the Eastpoint Business Center

From I-64 (East or West):

Take I-64 to the Gene Snyder Freeway/I-265 N.
Go north on the Gene Snyder Freeway/I-265 N.
Take the Old Henry Road exit (second exit).
Turn left off the ramp onto Old Henry Road.
Cross over the Gene Snyder Freeway/I-265.
Turn right at the first light into the Eastpoint Business Park.
Make an immediate left onto Magisterial Drive.
We are located in Magisterial Place II on the left-hand side of the street.

From I-71:

Take I-71 to the Gene Snyder Freeway/I-265 S.
Go south on the Gene Snyder Freeway/I-265 S.
Take the Old Henry Road exit (fourth exit).
Turn right off the ramp onto Old Henry Road.
Turn right at the first light into the Eastpoint Business Park.
Make an immediate left onto Magisterial Drive.
We are located in Magisterial Place II on the left-hand side of the street.

From Elizabethtown:

Take I-65 N to the Gene Snyder Freeway/I-265 E.
Go east on the Gene Snyder Freeway/I-265 E.
Take the Old Henry Road exit (second exit past I-64).
Turn left off the ramp onto Old Henry Road.
Cross over the Gene Snyder Freeway.
Turn right at the first light into the Eastpoint Business Park.
Make an immediate left onto Magisterial Drive.
We are located in Magisterial Place II on the left-hand side of the street.

From Southern Indiana:

Take I-65 S or I-64 E to I-71 N.
Take I-71 N to the Gene Snyder Freeway/I-265 S.
Go south on the Gene Snyder Freeway/I-265 S.
Take the Old Henry Road exit (fourth exit).
Turn right off the ramp onto Old Henry Road.
Turn right at the first light into the Eastpoint Business Park.
Make an immediate left onto Magisterial Drive.
We are located in Magisterial Place II on the left-hand side of the street.