Facial Pain and Sleep Center, PLC

Ghabi A. Kaspo, DDS
Diplomate, American Board of Orofacial Pain
Diplomate, American Board of Dental Sleep Medicine

WELCOME TO OUR PRACTICE!

Thank you for calling our office and giving us an opportunity to help you feel better.

We only treat patients suffering from TMJ disorders, facial pain and sleep apnea with the use of sleep appliances. The approach that we use represents the end result of many years of practice and research and has helped thousands of patients. Our staff is well trained and eager to help you—please read below to find out more about our diagnosis and treatment processes.

EVALUATION PROCESS

Your first visit will be for the purpose of evaluating your problem on a comprehensive basis. This will involve a review of your health history, clinical examination, x-rays, psychometric screening, and other diagnostic records. After the evaluation process is completed, your case will be discussed with you and a management program will be formulated and explained to you. On occasion, additional x-rays or consultations may be necessary.

TREATMENT

Your individualized management program may involve a wide variety of modern techniques. The total length and frequency of visits also varies with the needs of each patient. You may be seen as often as once a week or as little as once or twice a month.

YOUR ROLE IN THE TREATMENT

Patients who come to our clinic may have a complicated and long-standing problem. In order to make your treatment at the clinic most effective, we request the following:

1. Please feel free to ask questions and seek information
2. Please keep an open mind about the management program recommended for you
3. Please take the responsibility to become an active participant in your management.

Make the time and commitment to follow through with the entire program offered at the clinic.

COMPLETION OF TREATMENT

When you have received maximum benefit from the active phase of your treatment, you will be placed on a maintenance program. This usually consists of a series of follow up visits at periodic intervals to monitor your progress. If everything is satisfactory, your treatment at the clinic ends. If any additional outside services are needed, our staff at the clinic will assist you in making the necessary referrals.

We look forward to seeing you at your scheduled appointment.

IN ORDER TO DIAGNOSE AND TREAT YOU BETTER, PLEASE TAKE YOUR TIME AND COMPLETE THE ENCLOSED QUESTIONNAIRE CAREFULLY AND ACCURATELY BEFORE YOUR APPOINTMENT.

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WELCOME TO OUR PRACTICE!

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

The information you provide in this packet is vital and will assist the doctor during the review of your symptoms. Please respond to all questions. Questions contained within are confidential and will become part of your healthcare record. Some questions are intended for governmental/statistical purposes only.

FOR OFFICE USE ONLY

Chart #	_____	**Room#**	_____
T	_____	**Assistant**	_____
P	_____	**Shielded**	_____
BP	_____/_____	**Pregnant**	_____
02s	_____		

Date: _____

PATIENT INFORMATION

NAME _____ Female ☐ Male ☐
Last First Middle Initial

_____
Home Address City State Zip Code

_____/_____/_____ _____ _____ _____ _____ _____
Birthdate Age Height (Feet&Inches) Weight (Pounds) Neck Size Email Address

Marital Status: Married ☐ # of Children____ Ages: _____ Single ☐ Separated ☐ Divorced ☐ Widowed ☐

Ethnicity: Non-Hispanic ☐ Hispanic/Latino ☐

Race: White ☐ Black ☐ Hispanic ☐ American Indian/Alaska Native ☐ Asian ☐
Native Hawaiian/Pacific Islander ☐ Other _____

Language: English ☐ Spanish ☐ French ☐ Arabic ☐ Chinese ☐ Sign Language ☐

Education: None ☐ Grade 1-8 ☐ High School Incomplete ☐ High School Completed ☐ College ☐
Post Graduate ☐ Professional Training ☐ Other: _____

Employment: Full Time☐ Part Time ☐ Retired ☐ Disabled ☐ Unemployed ☐ Military ☐ Student ☐ Homemaker ☐

Patient Occupation: _____ Business Name: _____ Phone#: _____

_____
Business Street Address City State Zip

PATIENT TELEPHONE NUMBERS

Primary Number _____	Home ☐ Work ☐ Mobile ☐ Other _____ Mobile Carrier: (for texting): AT&T ☐ Sprint ☐ Verizon ☐ Other_____	May we leave a message? YES ☐ NO ☐
Alternate Number _____	Home ☐ Work ☐ Mobile ☐ Other _____ Mobile Carrier: (for texting): AT&T ☐ Sprint ☐ Verizon ☐ Other_____	May we leave a message? YES ☐ NO ☐
Alternate Number _____	Home ☐ Work ☐ Mobile ☐ Other _____ Mobile Carrier: (for texting): AT&T ☐ Sprint ☐ Verizon ☐ Other_____	May we leave a message? YES ☐ NO ☐

CONTACT & DISCLOSURE INFORMATION

Please provide contact name in case of an Emergency:

_____ YES ☐ NO ☐

Name of Individual | Relationship to Patient | Primary Phone Number | Leave a Message

Names of individuals to whom information about you may be disclosed:

1._____ YES ☐ NO ☐

Name of Individual | Relationship to Patient | Primary Phone Number | Leave a Message

2._____ YES ☐ NO ☐

Name of Individual | Relationship to Patient | Primary Phone Number | Leave a Message

If patient is a minor, provide name of parent/guardian who is responsible to bring the patient for treatment:

_____ YES ☐ NO ☐

Parent/Guardian Name | Relationship to Patient | Primary Phone Number | Leave a Message

_____

Street Address | City | State | Zip

TREATMENT FINANCIAL RESPONSIBILITY

Person Responsible for Payment of this Account – Self ☐ Other Individual ☐ - Please Complete Below:

_____ _____

Responsible Individual's Name | Relationship to the Patient | Date of Birth

_____

Home Address (If Different than Patient's Address) | City | State | Zip

_____ _____

Primary Phone Number | Alternate Phone # | May we Leave a Message? YES ☐ NO ☐

PRIMARY/MEDICAL INSURANCE INFORMATION

_____

Primary Insurance Company | Subscriber ID | Group # | Insurance Company Phone#

_____

Subscriber's Last Name | First Name | Relationship to the Patient | Date of Birth

ADDITIONAL INSURANCE INFORMATION

_____

Insurance Company | Subscriber ID | Group # | Insurance Company Phone#

_____

Subscriber's Last Name | First Name | Relationship to the Patient | Date of Birth

HEALTHCARE PROVIDER INFORMATION

Provider	Name	Address	City, State, Zip Code	Telephone	Do you authorize us to send your treatment information?
Referring Provider					YES ☐ NO ☐
Family Physician					YES ☐ NO ☐
Dentist					YES ☐ NO ☐
Other Provider					YES ☐ NO ☐

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

Address: _____City:_____ State: _____ Zip:_____

TMD RELATED SYMPTOMS

HISTORY OF CURRENT SYMPTOMS – Please provide your chief complaint (s) you seek evaluation of:

The severity of pain scale is from 0 to 10: 0 =NO PAIN 1-3 = MILD 4-7 = MODERATE 8-10 =SEVERE

AREA OF PAIN	LOCATION	RECENT (Up to 6 months)	CHRONIC (More than 6 months)	SEVERITY	DURATION	FREQUENCY
Frontal Head Pain (Forehead Area)	Right ☐ Left ☐ Both ☐	Date _____	Date _____	No Pain ☐ Mild ☐ Moderate ☐ Severe ☐	Minutes ☐ Hours ☐ Days ☐	Occasional ☐ Frequent ☐ Constant ☐
Parietal (Top of Head)	Right ☐ Left ☐ Both ☐	Date _____	Date _____	No Pain ☐ Mild ☐ Moderate ☐ Severe ☐	Minutes ☐ Hours ☐ Days ☐	Occasional ☐ Frequent ☐ Constant ☐
Occipital (Back of Head)	Right ☐ Left ☐ Both ☐	Date _____	Date _____	No Pain ☐ Mild ☐ Moderate ☐ Severe ☐	Minutes ☐ Hours ☐ Days ☐	Occasional ☐ Frequent ☐ Constant ☐
Temporal (Temples)	Right ☐ Left ☐ Both ☐	Date _____	Date _____	No Pain ☐ Mild ☐ Moderate ☐ Severe ☐	Minutes ☐ Hours ☐ Days ☐	Occasional ☐ Frequent ☐ Constant ☐
Ear pain	Right ☐ Left ☐ Both ☐	Date _____	Date _____	No Pain ☐ Mild ☐ Moderate ☐ Severe ☐	Minutes ☐ Hours ☐ Days ☐	Occasional ☐ Frequent ☐ Constant ☐
Facial Pain	Right ☐ Left ☐ Both ☐	Date _____	Date _____	No Pain ☐ Mild ☐ Moderate ☐ Severe ☐	Minutes ☐ Hours ☐ Days ☐	Occasional ☐ Frequent ☐ Constant ☐
Jaw Pain	Right ☐ Left ☐ Both ☐	Date _____	Date _____	No Pain ☐ Mild ☐ Moderate ☐ Severe ☐	Minutes ☐ Hours ☐ Days ☐	Occasional ☐ Frequent ☐ Constant ☐

JAW JOINT SYMPTOMS Please check applicable symptom (s) below:

Symptom	(R=Right	L=Left	B=Both)
Jaw locks closed	R ☐	L☐	B ☐
Jaw locks open	R ☐	L☐	B ☐
Jaw joint sounds on mouth opening	R ☐	L☐	B ☐
Jaw joint sounds on chewing	R ☐	L☐	B ☐
Jaw joint sounds while at rest	R ☐	L☐	B ☐

OTHER RELATED SYMPTOMS Please check applicable symptom (s) below:

Limited neck movement			☐
Neck pain			☐
Ear buzzing	R ☐	L☐	B ☐
Ear congestion	R ☐	L☐	B ☐
Hearing loss	R ☐	L☐	B ☐
Ear stuffiness/Itchiness	R ☐	L☐	B ☐

Do you experience any associated symptoms? NO ☐ YES ☐ (Please explain)_____

_____

*****Are your symptoms injury related? NO ☐ YES ☐ If YES, please complete the Injury Related Form**

Onset of Pain	Date	Describe Occurrence of Symptom (s)
Pain just began ☐		
Injury Type: Work Related ☐ Motor Vehicle Accident ☐ Other: _____		

ACCIDENTAL INJURY INFORMATION

Have you been in an accident at work or while driving because of sleepiness within the last year? NO ☐ YES☐

How often do you actually fall asleep while driving? Check one only below:

More than twice per month ☐ Very Rarely ☐
Once or twice per month ☐ Never ☐

Please describe your main work schedule: Day shift (9-5) ☐ Evening shift(3-11) ☐
Night shift (11-7) ☐ Flexible schedule ☐ Unemployed/Retired ☐

If you drink caffeinated beverages, when do you usually drink your last cup each day?

Before Noon ☐ Before 4:00 PM ☐ Before 8:00PM ☐ Within one hour of bedtime ☐

What time do you go to bed? Work Days _____ Non-Work Days _____

On average, how long does it take you to fall asleep at night:

Less than 5 Minutes ☐ 30 Minutes ☐ 1 Hour ☐ 1-2 Hours ☐ More than 2 Hours ☐

Approximately how many hours do you actually spend in bed?_____ How many hours do you sleep each night? _____

Have you ever been paralyzed (unable to move all of your muscles) for a short time when you first awaken?

NO ☐ YES ☐ How frequently does this occur?

How frequently do sleep problems interfere with work/home functioning (daily chores, concentration, memory, driving, etc.):

Always ☐ Often ☐ Rarely ☐ Never ☐

SLEEP HISTORY

Have you been previously diagnosed or treated for a sleep disorder condition? NO ☐ YES ☐ (If YES, please identify:)

Obstructive Sleep Apnea ☐ Central Sleep Apnea ☐ Insomnia ☐ Narcolepsy ☐
Restless Legs Syndrome ☐ Periodic limb movement ☐ Other: ☐ _____

From the list below, check your primary sleep related problem(s) or the symptom(s) that best suits you:
Snoring ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Impaired cognition ☐ Unusual behavior during sleep ☐
Tired/sleepy during the day ☐ Gasping/choking / repeated pauses in breathing while sleeping ☐ Morning headache ☐

Have you ever had a sleep study? NO ☐ YES ☐ (If YES, please complete below entry.)

Sleep Doctor Name Name/Center	Address	City	State	Zip Code	Sleep Study Date	Telephone #

CPAP INTOLERANCE

If you have attempted treatment with a CPAP device, but could not tolerate it, list reasons below:

A latex allergy ☐	Disturbed sleep caused by presence of device ☐
An unconscious need to remove the CPAP at night ☐	I was unable to get the mast to fit properly ☐
Claustrophobic association ☐	Mask leaks ☐
CPAP does not seem to be effective ☐	Noise from device disturbing my/partner's sleep ☐
CPAP restricted movements during sleep ☐	Pressure on the upper lip causing tooth issues ☐
Discomfort caused by the straps and headgear ☐	Other: _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

Surgeries ☐ _____	Weight Loss Attempts ☐
Smoking Cessation for at least one month ☐	Other: _____

THE EPWORTH SLEEPING SCALE

Select the number below that best describes your chance of dozing in each situation:

SITUATION	NEVER	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
As a passenger in a car for 1 hour without a break	**0**	**1**	**2**	**3**
In a car while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon	**0**	**1**	**2**	**3**
Sitting and reading	**0**	**1**	**2**	**3**
Sitting and Talking	**0**	**1**	**2**	**3**
Sitting inactive in a public place	**0**	**1**	**2**	**3**
Sitting quietly after lunch with no alcohol	**0**	**1**	**2**	**3**
Watching Television	**0**	**1**	**2**	**3**

ADD TOTAL NUMBER OF POINTS FROM ABOVE: _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of: Mild ☐ Moderate Obstructive Sleep Apnea ☐ Severe ☐

THE EVALUATION SHOWED

		During REM	Supine	Side
An RDI OF	_____			
An AHI OF	_____			

MEDICATIONS

Are you taking any prescribed/over the counter medications and vitamins? NO ☐ YES☐ (If YES, Please list below:)

Medication	Strength	Unit	Amount	Frequency	Started On	Notes/Taken for
Example: Lipitor	10	Mg	1	Once Daily	01/10/2010	High Cholesterol
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

ALLERGIES

Do you have any allergies: NO ☐ YES ☐ (If YES, please list below:)

Allergy Type	Reaction

HEALTH & MEDICAL HISTORY

As of today's visit, are you or could you be pregnant: NO ☐ YES ☐ Due Date:_____
Are you currently breastfeeding: NO ☐ YES ☐

HEALTH & MEDICAL CONDITION Please check applicable condition(s) you have or had in the past:

Condition	Start Date	Comments		Condition	Start Date	Comments
Aids ☐				Mental Illness ☐		
Anemia ☐				Migraine Headaches ☐		
Asthma ☐				Muscular Dystrophy ☐		
Blood Pressure High ☐ Low ☐				Narcolepsy ☐		
Cancer ☐				Osteoporosis ☐		
Degenerative Arthritis ☐				Pneumonia ☐		
Diabetes Type 1 ☐				Prostate Problems ☐		
Diabetes Type 3 ☐				Psychiatric Care ☐		
Emphysema/COPD ☐				Restless leg Syndrome ☐		
Epilepsy/Seizures ☐				Rheumatoid Arthritis ☐		
Gallbladder Disease ☐				Sinus Problems ☐		
Glaucoma ☐				Sleep Apnea ☐		
Headaches Frequent ☐				Sleep Walking ☐		
Heart Disease ☐				Stroke / TIA ☐		
Hepatitis Type A ☐				Thyroid Disease ☐		
Hepatitis Type B ☐				Tuberculosis ☐		
Hepatitis Type C ☐						
HIV Positive ☐						
Insomnia ☐						
Kidney Disease ☐						
Liver Disease ☐						

REVIEW OF SYSTEMS Please check applicable condition(s):

GENERAL	EAR/NOSE/MOUTH/THROAT	RESPIRATORY
Good Health Lately YES ☐ NO ☐	Bleeding gums ☐	Frequent Cough ☐
Confusion ☐	Burning mouth ☐	Shortness of Breath ☐
Depression ☐	Difficulty Swallowing ☐	
Fatigue ☐	Dry Mouth ☐	**ENDOCRINE**
Fever ☐	Ear Drainage R ☐ L ☐ B ☐	Change in Hat or Glove Size ☐
Forgetfulness ☐	Ear Pain R ☐ L ☐ B ☐	Glandular/Hormone Problems ☐
Injury to the face R ☐ L ☐ B ☐	Loss of Hearing ☐	Thyroid Disease ☐
Injury to the neck ☐	Nose Bleeds ☐	
Injury to the mouth ☐	Ringing in ear R ☐ L ☐ B ☐	**NEUROLOGICAL**
Injury to the teeth ☐	Sinus Problems ☐	Convulsions ☐
Loss of sleep ☐	Sore Throat ☐	Facial Numbness R ☐ L ☐ B ☐
Memory Loss ☐	Swollen Glands ☐	Headaches – Chronic ☐
Nervousness ☐		Headaches-Recurring ☐
Radiation Treatment ☐	**MUSCULOSKELETAL**	Lightheadedness/Dizziness ☐
Recent Weight Gain-Unexplained ☐	Back Pain ☐	Numbness ☐
Recent Weight Loss-Unexplained ☐	Facial Muscle Pain R ☐ L ☐ B ☐	Paralysis ☐
Shortness of Breath ☐	Jaw joint Pain R ☐ L ☐ B ☐	Seizures ☐
Whiplash Injuries ☐	Jaw Joint Stiffness R ☐ L ☐ B ☐	Tingling Sensations ☐
	Jaw Joint Swelling R ☐ L ☐ B ☐	Tremors ☐
CARDIOVASCULAR	Neck Pain ☐	
Blood Pressure –High ☐	Weakness of Facial Muscles R ☐ L ☐ B ☐	**GASTROINTESTINAL**
Blood Pressure –Low ☐	Weakness of Jaw Joint (s) R ☐ L ☐ B ☐	Excessive Thirst ☐
Chest Pain ☐		Loss of Appetite ☐
Heart Problems ☐	**EYES (RIGHT/LEFT/BOTH)**	Nausea ☐
Irregular Heart Beat ☐	Eye Disease R ☐ L ☐ B ☐	Peptic Ulcer ☐
Sudden Heart Beat Changes ☐	Eye Injury R ☐ L ☐ B ☐	Stomach Pain ☐
Swelling of Feet/Ankle/Hands ☐	Eye Twitching R ☐ L ☐ B ☐	Vomiting ☐

SURGICAL HISTORY Check applicable condition(s) below:

Surgery		Date		Surgery		Date
Adnoidectomy	☐			Rhinoplasty	☐	
Jaw Joint	☐			Tonsillectomy	☐	
Orthognathic	☐			Other:_____		

FAMILY HISTORY Check applicable condition(s) below:

CONDITION -	FAMILY MEMBER (S) WITH RELATED CONDITION
Heart Disease ☐	Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather ☐
Kidney Disease ☐	Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather ☐
Liver Disease ☐	Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather ☐
Sleep Apnea ☐	Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather ☐
Temporomandibular Disorders☐	Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather ☐
Other: _____ ☐	Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather ☐
Other: _____ ☐	Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandmother ☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather ☐

HEALTH HABITS & SOCIAL HISTORY Please circle applicable area(s) below:

Tobacco Use	None	☐	Rarely	☐	Moderate	☐	Daily ☐
Alcoholic Beverages	None	☐	Rarely	☐	Moderate	☐	Daily ☐
Recreational Drugs	None	☐	Rarely	☐	Moderate	☐	Daily ☐
Caffeine Use	None	☐	Less than 3 cups/day	☐	3-6 cups/day	☐	More than 6 cups/day ☐
Exercise	None	☐	Very Little	☐	Moderate	☐	Regular ☐
Physical Activity	None	☐	Very Little	☐	Moderate	☐	Regular ☐
Eating Habits	Well	☐	Regular	☐	Light	☐	
Social Activity	None	☐	Very Little	☐	Moderate	☐	Regular ☐

I, the patient attest to the best of my knowledge, all of the above information is correct. I understand that I must provide at least a 24 business-hour cancellation notice. Otherwise, I will be charged a $50.00 cancelation fee. I understand that I am responsible for all charges incurred for my treatment or my child's' treatment regardless of insurance coverage. As a courtesy, my appropriate insurance carrier may be billed for the rendered services. I hereby authorize the release of pertinent health information to the insurance company, or for legal documentation and/or to process claims. I hereby authorize my insurance benefits to be paid directly to Dr. Ghabi A. Kaspo at Facial Pain and Sleep Center, PLC otherwise payable to me, realizing that I am responsible to pay for my treatment, and for the non-covered services. I understand that I am responsible for charges/lab fees incurred for the appliance/mouth piece should I fail to present for the appliance insertion appointment. Charges not paid within 45 days will have a service/handling charge of $10.00 per month added to the past due balance on each monthly statement thereafter. If payment is not submitted, I, the undersigned also agree to pay any reasonable attorney fees and costs which are incurred by Dr. Ghabi Kaspo at the Facial Pain and Sleep Center, PLC in collecting payment for services rendered.

I authorize the release of a full report of my records comprising of examination findings, diagnosis, imaging, treatment program, progress notes, etc., to my referring/treating or mutual providers. Copies of my records or x-rays may be released to me or to another party authorized by me upon my timely request and payment of appropriate fees.

_____

Patient/Parent/Guardian Signature **Date**

Date Updated : _____Patient/Parent/Guardian Signature_____

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WELCOME TO OUR PRACTICE!

LOCATIONS

We look forward to seeing you at one of the offices noted below per your scheduled initial appointment.

Troy
3144 John R Road, Suite 100, Troy, MI 48083
This office is just north of 16 Mile Road on the east side of John R Road.

Bingham Farms
31000 Telegraph Road, Suite 110, Bingham Farms, MI 48025
This office is just north of 13 Mile Road on the east side of Telegraph Road.

Due to high traffic volumes in the area, it is advisable to allow an extra 30 minutes for prompt arrival.

APPOINTMENTS

Please arrive 15 minutes early to your first scheduled appointment so you may register. Late arrivals may have to be rescheduled. Your first appointment takes between 60 to 90 minutes. It is imperative that present timely. If you are unable to make your appointment, please call our office at (248)-519-1100 at least 24 hours in advance to reschedule. If you do not present to your scheduled appointment, we may not be able to reschedule your appointment for quite some time.

REGISTRATION

Please give all records and forms to the front desk staff—they will help you register in our office.

PREVIOUS RECORDS

If available, please bring to your initial appointment any x-rays or medical/dental records relating to the symptoms that you seek treatment for, taken within the past 6 months.

FINANCES & PAYMENT

It is our office policy that fees are paid at the time services are rendered. TMJ treatment and oral appliance treatment for obstructive sleep apnea are normally covered under medical, not dental insurance. However, this may vary amongst employers and insurance companies. We will gladly help you with insurance claims to expedite reimbursement. Accident and worker's compensation cases may have different arrangements.

THANK YOU AND WE LOOK FORWARD TO SEEING YOU AT YOUR SCHEDULED APPOINTMENT.

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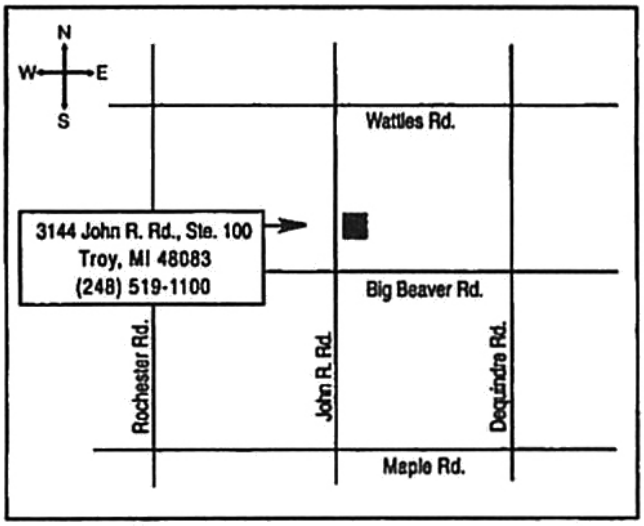
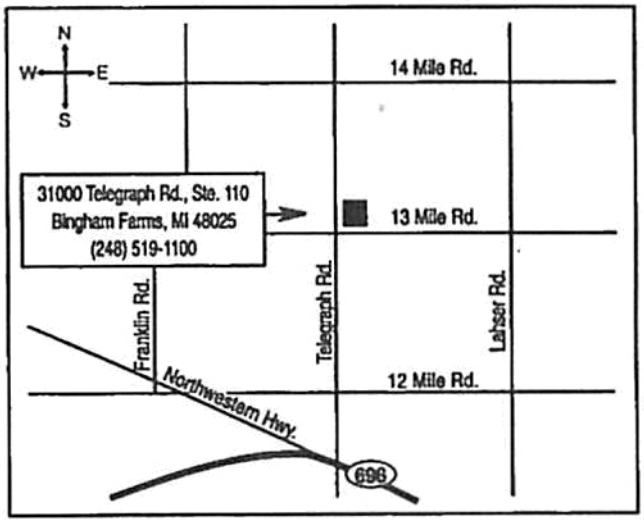
TROY



Office is located on the east side of John R Road, just north of Big Beaver Road

BINGHAM FARMS



Office is located on the northeast corner of 13 Mile Road and Telegraph