

J. BYRON STONE, M.D.
New Patient Request

You may fax this request without a cover sheet to our secure fax @ (512)451-7745. Please allow our office up to seven business days to review your information and return your call.

Please note: Dr. Stone's practice is private pay only, but upon request, we will provide a receipt with the needed information for you to submit to your insurance company for any out-of-network benefits.

Patient Name: _____ Today's Date: _____

Parent(s) Name(s) (if patient is child/adolescent): _____

Preferred Contact phone #: (_____) _____ OK to leave voicemail? _____

Patient's Age: _____ DOB: _____ Male _____ Female _____

Referred by: _____

School: _____ Primary Care Physician: _____

Brief reason for visit: _____

Interfering with work? _____ Filing for disability (FMLA)? _____

Interfering with school?

Any upcoming legal issues? _____ If yes, explain: _____

Any substance abuse issues? _____ If yes, explain: _____

Previous Mental Health Hospitalizations? _____ If yes, Date(s)/Hospital/City, State: _____

Other medical problems: _____

List all medications, herbs, and nutritional supplements patient is currently taking:

Medication, Herb, Supplement	Dose (mg; times/day, etc.)	Prescribed by: