

Request to Attending Physician

担当医へのお願い

1. Please fill in this form so that the patient may claim the health insurance benefit.
この様式は患者の健康保険の給付の申請に必要ですので、証明をお願いします。
2. This form should be completed and signed by the attending physician.
この様式は担当医が記入し、かつ署名してください。
3. One form for each month and one form for hospitalization/ outpatient (home visit) should be filled out. 各月毎、また入院・入院外毎につき、この様式1枚が必要です。

Form C

Attending Dentist's Statement

様式C

歯科診療内容明細書

1. Name of Patient (Last, First) 患者名	Age (Date of birth) 年齢(生年月日)	Sex (Male • Female) 性別
2. Date of first Diagnosis 初診日	3. Days of Diagnosis and Treatment 診療日数 days	

Permanent tooth				Primary tooth																													
(Upper)	(RIGHT)	(LEFT)	(RIGHT)	(LEFT)	(RIGHT)	(LEFT)	(LEFT)																										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J								
(Lower)	(RIGHT)	(LEFT)	(RIGHT)	(LEFT)	(RIGHT)	(LEFT)	(LEFT)	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Type of Treatment 治療の分類

Dental Treatment 歯科治療	Localization of Teeth Examined 患歯部位	Date			Fee 治療費
		MO.	DA.	YR.	
Initial Office Visit 初診料					
X-ray Examination レントゲン検査					
Dental Pulp Extirpation 抜髄					
Operation 手術					
Extraction 抜歯					
Filling 充填					
Inlay インレー					
Metal Crown 金属冠					
Post Crown 継続歯					
Jacket Crown ジャケット冠					
Bridge Work ブリッジ					
Plate Denture 有床義歯					
Partial Denture 局部義歯					
Complete Denture 総義歯					
Treatment of Pyorrhea Alveolaris 歯槽膿漏処置					
Medicine 投薬					
The Others その他					
Total 合計					

Name and Address of Attending Physician

担当医の名前及び住所

Name Last(姓) First(名)

Title(称号)

Address Home(自宅)

Phone(電話)

Office(病院または診療所)

Phone

Date(日付)

Signature(署名)

Attending Physician(担当医)

Reference Number of your Medical Record(if applicable)

診療録の番号