



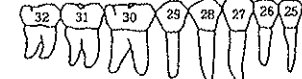
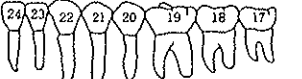




Request to Attending Physician
担当医へのお願い

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
様式C

Attending Dentist's Statement
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)	  (LEFT)	
(Lower) (RIGHT)   (LEFT)	  (LEFT)	

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 _____