Attending Physician's Statement

診療内容明細書

1 .	Name of Patient (Last, First) Age (Date of Birth) Sex (Male·Female) 患者名 年齢(生年月日) 性別(男・女)
2 .	Name of Illness or Injury preferably with Number of International Classification of diseases for the use of National Health Insurance (See the other side of this form) - 傷病名及び国民健康保険用国際疾病分類番号(裏面参照)
3 .	Date of First Diagnosis: D / M / Y / / 初診日 日 / 月 / 年 / /
4 .	Duration of Treatment:days 診療日数日
5.	Type of Treatment 治療の分類 Hospitalization: From / / , to / / (days) 入院 自 / / 至 / / (日間) Out patient or Home Visit: / / / / / / / / / / / / / / / / / / /
6.	Nature and Condition of Illness or Injury (in brief) 症状の概要
7.	Prescription, Operation and Any other treatments (in brief) 処方、手術その他の処置の概要
8 .	Was the treatment required as a result of an accidental injury? Yes No 治療は事故の傷害によるものですか。 はい いいえ
9 .	Itemized Amounts paid to Hospital and/or Attending Physician:Form B 治療実費 様式B
10 .	Name and Address of Attending Physician 担当医の名前及び住所 Name名前 : <u>Last姓 First名 Title 称号</u> Address住所 : <u>Home</u> 自宅 phone電話
	Office病院又は診療所 phone電話
	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