Attending Physician's Statement 診療内容明細書

1.Name of Patient(Last,First) 患者名		<u> </u>			Sex (Male・Female) 性別(男・女)
2.Name of Illness or diseases for the us 傷病名及び国民	e National Hea	lth Insurance (See the othe		
3.Date of First Diagr 初診日	nosis: <u>D / M / Y</u> <u>日/月/年</u>		<u>/</u>		
4.Duration of Treatn 診療日数	nent:				
5.Type of Treatment 治療の分類					
□Hospitalizat	tion:From/	/,to	1 1	(days)
入院		/至			日間)
□Out patient	or Home Visit:	/ /			
入院外		1 1	/		
6.Nature and Condit 症状の概要	ion of Illness or	· Injury (in brie	f)		
7.Prescription, Opera 処方、手術その他の	_	ther treatment	s(in brief)		
8.Was the treatment 治療は事故の傷害に	_		dental injur	_	No□ いいえ
9.Itemized Amounts 治療実費	paid to Hospita	ll and / or Atten	ding Physic	ian:From 様式B	
10.Name and Addres 担当医の名前及び信	9	Physician			
Name 名前	: <u>Last 姓</u>	First 名	Title ₹		
Address 住所	:Home 自宅		phon	ie 電話	
	Office 病院又は診療所 phone 電話				
Date 日付:	Signature 署名				
			Atte	ending Phy	sician 担当医

Reference Number of your Medical Record(if applicable)

診療録の番号_____