Form A

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
傷病名及び国民健康保険用国際疾病分類番号 _____

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: ___/___/___ ___/___/___
入院外 ___/___/___ ___/___/___

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 : Last 姓 _____ First 名 _____ Title 称号 _____
Address 住所 : Home 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 _____