Form A

Attending Physician's Statement
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(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 ____________