## 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 social insurance benefit. この様式は患者の社会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書き、かつ署名をして下さい。
- 3. One form for each month and one form for hospitalization/outpatient (home visit) should be filled out. 各月毎、入院・入院外毎に付、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)

Name of pa (患者名 <u>)</u>	tient	(Last, First)	Age(Date of Birth) 年令(生年月日)		Sex(I (男・z		· Fer	male)	
Date of First Diagnosis(初診日) <u>:</u> 20									
Days of Diagnosis and Treatment(診療日数):days									
Permanent tooth (Upper)	<u>(1</u>	2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	RIGHT)	ary A B	C D	E F	GHI, J	(LEFT)
(Tower)	(32)	31 (*30) (29) (28) (27) (26) (25)	24/23/22/21/20/19/18/17	(LEET) (RIGHT)	T S	(R)Q)	P O	NM L K	AT)
Tooth No.			tion of Service			Date	<u> </u>	Amount	
or Letter	(]	ncluding X-Rays. Prop	hylaxis. Materials used. ET	.C.)	MO.	DA.	YR.	Allioulit	
									_
					Tota	1 Δm	ount		
<b>.</b>		1 4 1 1	D 11.1		1014	1 / 1111	ount		
		l Address of Attending	Dentist						
(担当	医の名	前及び住所)							
Nam	e	:Last(姓)		Fir	·st(名)	)			
Address : Home(自宅)			I	Phone					
		Office(病院又は診療所)		I	Phone				
Date		•	Signatu	ıre(署名	<u>(1)</u>				
					At	tendi	ng D	entist (担当	医)
			Reference Number	of your	Medi	ical F	Record	d (if applica	ble)
	(診療録の番号)								

## Itemized Receipt (DENTAL)

領収明細書 (歯科)

Name of Patient 受診者名 _		Age 年令 Sex (Male Female) 性別 Days of Diagnosis and Treatment						
Date of First Diagnosis 初診日 _	D	ays of Diagnosis and Tr 診断日	eatment 日数 <u>days</u>					
		of Teeth  部位						
Permanent Teeth	Permanent Teeth 永久歯 Deciduous Teeth 乳菌							
	65 5 4 3 2 1   1 2 3 4 5 6 7 8   1 2 3 4 5 6 7 8   1 2 3 4 5 6 7 8   1 2 3 4 5 6 7 8   1 2 3 4 5 6 7 8   1 2 3 4 5 6 7 8   1 2 3 4 5 6 7 8   1							
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87034321	12345678	е а с в а а в е	c d e					
1. Name of Illness 傷病名								
1. Dental Caries 2. う蝕症	2. Missing Teeth 欠損	3. Pyorrhea 歯槽膿漏 	4. The Others その他 「					
2. Dental Treatment L		Material	Fee					
歯科診療	Teeth Examined 患ī	歯部位 材料	料治療費					
* Initial office Visit 初診料								
* X-Ray Examination レントゲン検査								
* Dental Pulp Extirpation 技髓								
* Extraction 抜歯								
* Filling 充填								
* Inlay								
* 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 服薬								
* The Others その他								
Name of Dental Surgeon 医師氏名 Name and Address of Denti		Total Signature 署名	合計 ————————————————————————————————————					
歯科医院の名称及び所在								