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 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

Office 病院又は診療所 Phone

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 _____