

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 (See the other side of this form)  
傷病名及び国民健康保険用国際疾病分類番号(裏面参照)

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 \_\_\_\_\_