

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 \_\_\_\_\_