FormC

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 health insurance benefit.
この様式は患者の健康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記入し、かつ署名してください。
3.One form for each month and one form for hospitalization / outpatient visit (home visit) should be filled out.
各月毎、また入院・入院外毎につき、この様式が1枚必要です。

Attending Dentist's Statement
歯科診療内容明細書

Name of Patient (Last, First) (患者名)	Sex (性別) Male (男性) · Female (女性)	Age (年齢)	Date of Birth (生年月日) / / Month Day Year
Date of First Diagnosis (初診日) / / Month Day Year	Days of Diagnosis and Treatment (診療日数) Days		Medical Record Number (診療録番号)

*Please circle the treated tooth (治療した歯に○をつけてください)

Permanent Teeth (永久歯)

R 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 L
R 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17 L

Primary teeth (乳歯)

R A B C D E | F G H I J L
R T S R Q P | O N M L K L

*Please circle the appropriate one (該当するものに○をつけてください)

・Cavity(C) (虫歯) ・missing teeth(F) (欠歯) ・Stomatitis(G) (口内炎)
・Pyorrhea alveolaris(P) (歯槽膿漏) ・extraction needed(Z) (要抜歯)
・The Other (その他)( )

Dental Treatment (歯科治療)	Tooth No. and Surface (患歯番号・患歯部位)		Date (治療日) Month	Day	Year	Fee (治療費)
Initial Office Visit (初診料))	No.					
X-Ray Examination (レントゲン検査)	No.					
Pulpectomy (抜髄)	No.					
Extraction (抜歯)	No.					
Filling (充填)	No.					
Inlay (インレー)	No.					
Metal Crown (金属冠)	No.					
Post Crown (継続歯)	No.					
Jacket Crown (ジャケット冠)	No.					
Bridge (ブリッジ)	No.					
Plate Denture (有床義歯)	No.					
Partial Denture (局部義歯)	No.					
Complete Denture (総義歯)	No.					
Treatment of Pyorrhea Alveolaris (歯槽膿漏処置)	No.					
Medication (投薬)	No.					
Others ( ) (その他)	No.					
					Total Fee (合計)	

ATTENDING PHYSICIAN INFORMATION (担当医情報欄)

Medical Institution Name (医療機関名)

Address (住所)

Name of Dentist (担当歯科医者) Title (称号)

Signature (署名) Phone (電話)

Date Completed (作成年月日) . .