Form A

Attending Physician's Statement

診療内容明細書

1. Name of Patient (Last, First) 患者名 ____________ Age (Date of Birth) 年齢(生年月日)____________ Sex (Male·Female) 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 ____________