Form C
様式 C

Request to Attending Physician
担当医へのお願い

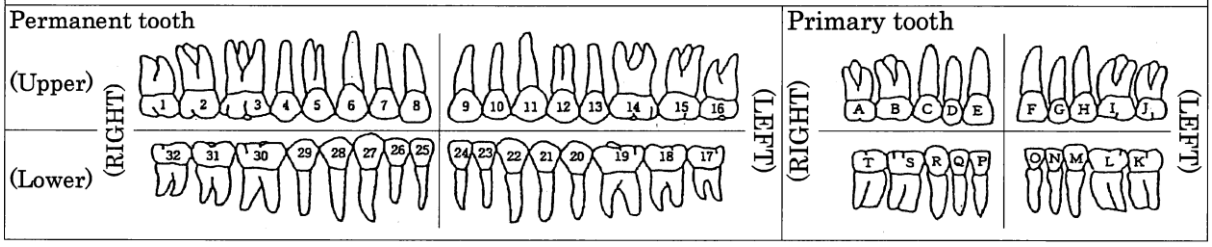
- This form is used for claiming the social insurance benefit.
  (この様式は社会保険の給付の申請にしようされます。)
- This form should be completed and signed by the attending physician.
  (この様式は担当医が書き、かつ署名して下さい。)
- One form for each month, one form for hospitalization / outpatient and home visit.
  (各月毎、入院・入院外毎につき、この様式１枚が必要です。)
- Separate receipt required for prescriptions (薬材料は別途、処方箋を添付のこと)

Attending Dentist's Statement
(歯 科 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

2. Date of first Diagnosis 初診日 ___ . ___ . ___

3. Days of Diagnosis and Treatment 診療日数 _____ days



Type of Treatment 治療の分類

Tooth No. of Letter	Description of Service Including X-Rays, Prophylaxis, Materials used, etc.	Date MO.	Date DA.	Date YR.	Fee
	Total (合計)				

Name and Address of Attending Physician (担当医の氏名及び住所)

Ｎａｍｅ Last (姓) _____ First (名) _____

Address 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 _____