

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  
傷病名及び国民健康保険用国際疾病分類番号

3. Date of First Diagnosis : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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 \_\_\_\_\_