

Attending Dentist's Statement

(様式 C)

診療内容明細書(歯科)

Request to Attending physician 担当医へお願い																																																									
1. Please fill in this form so that the patient may claim the National Health insurance benefit. この様式は患者の国民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、署名してください。 3. One form for each month and one for hospitalization / outpatient(home visit) should be filled out. 各月毎、入院・入院外毎に、この様式 1 枚が必要です。 Separate receipt required for prescriptions. 薬材料は別に処方箋を添付のこと。																																																									
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Permanent (疾病の名称および部位)</td> <td style="width: 50%;">Baby teeth (乳歯)</td> </tr> <tr> <td style="text-align: center;"> <table border="1" style="margin: auto;"> <tr> <td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> </tr> <tr> <td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> </tr> </table> </td> <td style="text-align: center;"> <table border="1" style="margin: auto;"> <tr> <td>V</td><td>IV</td><td>III</td><td>II</td><td>I</td> <td>I</td><td>II</td><td>III</td><td>IV</td><td>V</td> </tr> <tr> <td>V</td><td>IV</td><td>III</td><td>II</td><td>I</td> <td>I</td><td>II</td><td>III</td><td>IV</td><td>V</td> </tr> </table> </td> </tr> </table> Identify examined teeth : (該当する部位を○で囲み病名をつける) ・ Cavity (C) (虫歯) ・ missing teeth (F) (欠歯) ・ stomatitis (G) (口内炎) ・ Phrrhes alveolaris (P) (歯槽膿漏) ・ extraction needed (Z) (要抜歯)		Permanent (疾病の名称および部位)	Baby teeth (乳歯)	<table border="1" style="margin: auto;"> <tr> <td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> </tr> <tr> <td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> </tr> </table>	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	<table border="1" style="margin: auto;"> <tr> <td>V</td><td>IV</td><td>III</td><td>II</td><td>I</td> <td>I</td><td>II</td><td>III</td><td>IV</td><td>V</td> </tr> <tr> <td>V</td><td>IV</td><td>III</td><td>II</td><td>I</td> <td>I</td><td>II</td><td>III</td><td>IV</td><td>V</td> </tr> </table>	V	IV	III	II	I	I	II	III	IV	V	V	IV	III	II	I	I	II	III	IV	V
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Date of First Diagnosis(初診日) _____ Days of Diagnosis and Treatment(診療を行った実日数) _____ day(日間) Office Visit Fees(診断料) _____ Examination Fees (検査料) _____ X-Ray Fee(レントゲン) _____ Other(その他) _____	Currency paid (支払通貨) _____ _____ _____																																																								
Services (治療した歯の部位と治療の種類)																																																									
Describe when gold or platinum was used(治療材料に金、白金を使用したときは特記してください)																																																									
・Filling (充てん)																																																									
・Inlaying (インレー又はアンレー)																																																									
・Capping (metal) (金属冠)																																																									
・Jacket capping (ジャケット冠)																																																									
・Capping connected (歯冠継続歯)																																																									
Chipped Teeth (欠損歯を補綴した場合その部位と種類)																																																									
・Bridge (ブリッジ)																																																									
・Partial artificial teeth (局部義歯)																																																									
・Total artificial teeth (総義歯)																																																									
Name of Hospital or Clinic (病院又は診療所名称) _____ Signature of Doctor (担当医署名) _____ Date (日付) _____	Total (計) _____ _____																																																								