

1. 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使用されます。)
2. One form for each month, one form for hospitalization/outpatient and home visit.
(各月毎, 入院・入院外毎に付この様式1枚が必要です。)

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 (傷病名) _____ (翻訳) _____

3. Date of First Diagnosis (初診日) _____

4. Date of Diagnosis and Treatment (診療実日数) _____ days

5. Type of Treatment (診療の分類) Hospitalization (入院) From _____ To _____ (_____ days)
 Out patient or Home Visit (入院外) _____

6. Nature and Condition of Illness or Injury (in brief) (症状の概要)

	(翻訳)
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7. Prescription, operation and any other treatments (in brief) (処方, 手術その他の処置の概要)

	(翻訳)
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8. Was the treatment required as a result of an accidental injury? (診療は事故の傷害によるものですか。)

YES NO

9. Itemized amounts paid to Hospital and/or Attending Physician (診療実費)

(1) Fee for Initial Office Visit	(初診料)	_____	(9) X-ray Examinations	(X線検査費)	_____
(2) Fee for Follow-UP Office Visit	(再診料)	_____	(10) Laboratory Tests	(諸検査費)	_____
(3) Fee for Home Visit	(往診料)	_____	(11) Medicines	(医薬費)	_____
(4) Fee for Hospital Visit	(入院管理料)	_____	(12) Surgical Dressing	(包帯費)	_____
(5) Hospitalization	(入院費)	_____	(13) Anaesthetics	(麻酔費)	_____
(6) Consultation	(診察費)	_____	(14) Operating Room Charge	(手術室費用)	_____
(7) Operation	(手術費)	_____	(15) The Others (Specify)	(その他/特記せよ)	_____
(8) Professional Nursing	(職業看護婦費)	_____	(16) other medical certificate	(文書代)	_____
			(17) Total (合計)		_____

Important : Exclude the amount irrelevant to the treatment, i.e., payment for luxurious room charge .

Name and Address of Attending physician / Superintendent of Hospital or Clinic (担当医又は病院事務長の名前及び住所)

Name : Last _____ First _____ Title _____
 (名前) (姓) (名)

Address : Home (自宅) _____ Phone _____
 Office (病院又は診療所) _____ Phone _____

Date : _____ Signature _____
 (日付) (署名)