

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。)

チェックポイント (歯科)

Attending Physician's Statement (DENTAL)
(診療内容明細書) (歯科)

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)

Date of First Diagnosis (初診日) _____

Date of Diagnosis And Treatment (診療日数) _____ days

Localization of Teeth (部位)

Permanent Teeth (永久歯)

Deciduous Teeth (乳歯)

R	8 7 6 5 4 3 2 1		1 2 3 4 5 6 7 8	L
	8 7 6 5 4 3 2 1		1 2 3 4 5 6 7 8	

R	e d c b a		a b c d e	L
	e d c b a		a b c d e	

1 . Name of Illness (傷病名)

1 . Dental Caries
(う蝕症)

2 . Missing Teeth
(欠損)

3 . Pyorrhea Alveolaris
(歯槽膿漏)

4 . The Others
(その他)

2 . Dental Treatment (歯科治療)	Localization of Teeth Examined (患歯部位)	Material (材料)	Fee (治療費)
Initial Office Visit (初診料)			
X - Ray Examination (レントゲン 検査)			
Dental Pulp Extirpation (抜髄)			
Extraction (抜歯)			
Filling (充填)			
Inlay (インレー)			
Metal Crown (金属冠)			
Post Crown (継続歯)			
Jacket Crown (ジャケット冠)			
Bridge Work (ブリッジ)			
Plate Denture (有床義歯)			
Partial Denture (局部義歯)			
Complete Denture (総義歯)			
Treatment of Pyorrhea Alveolaris (歯槽膿漏処置)			
Medicine (投薬)			
The Others (その他)			

Total (合計)

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
(住所) Office (病院又は診療所) Phone

Date : _____
(日付)

必ず記入されていることを確認

Signature
(署名)