Attending Physician's Statement

診療内容明細書

1.	Name of Patient (Last, First) 患者名							
2.	Name of Illness or Injury preferably with Number of International Classification of diseases for the use of 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 Diagno 初診日	esis: D	/ M /	/ Y / 年		/		
4.	Duration of Treatment:days 診療日数日							
5.	Type of Treatment 治療の分類 □ Hospitalization: 入院 □ Out patient or 入院外	自	/ /	至		(days) 日間)	
6.	Nature and Condition of Illness or Injury (in brief) 症状の概要							
7.	Prescription, Operation 処方、手術その他の処置の	•	other tre	atments (in	brief)			
8.	Was the treatment re 治療は事故の傷害によるもの		a result	of an acc		? Yes [
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			名	Title 称号			
	Address 住所 :Hom	ie 自宅						
	Offic	e病院又は診	僚所	Management of the control of the con	phone電	舌		
	Date 日付: Signature 署名Attending Physician						m扣平区	
		Reference	Number	of your N 診療録の番	Medical Recor	-		