

様式A (Form A)

Attending Physician's Statement

診療内容証明書

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 (See the other side of this form)
傷病名及び国民健康保険用国際疾病分類番号(別紙参照) _____
3. Date of First Diagnosis: D / M / Y _____
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 _____