# Request to Attending Physician

## 担当医へのお願い

1. Please fill in this from so that the patient may claim the health insurance benefit.
   この様式は患者の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、かつ署名してください。
3. One form for each month and one form for hospitalization/outpatient(home visit)should be filled out.
   各月ごと、また入院・入院外ごとにつき、この様式１枚が必要です。

Form C

## Attending Dentist's Statement

様　式　C

## 歯　科　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. Date of first Diagnosis　初　診　日 ____.____.____
3. Days of Diagnosis and Treatment　診療日数_____days

Permanent tooth

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (Upper) | (RIGHT) | | | | | | | | | | | | | | | | | (LEFT) |
| (Lower) | | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | |

Primary tooth

| | | A | B | C | D | E | F | G | H | I | J | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (RIHGT) | | | | | | | | | | | | (LEFT) |
| | | T | S | R | Q | P | O | N | M | L | K | |

Type of Treatment　治療の分類

| Dental Treatment<br>歯科治療 | Localization of Examined<br>患歯部位 | Date | | | Fee<br>治療費 |
|---|---|---|---|---|---|
| | | MO. | DA. | YR. | |
| Initial Office Visit　初診料 | | | | | |
| X-Ray Examination レントゲン検査 | | | | | |
| Pulp & Root Canal Treatment　歯髄・根管治療 | | | | | |
| a) Pulp Extirpation with Immediate Root Canal Filling（抜髄即充） | | | | | |
| b) Pulp Extirpation Only（抜髄・根充なし） | | | | | |
| c) Root Canal Filling（根管充填） | | | | | |
| Operation　手術 | | | | | |
| Extraction　抜歯 | | | | | |
| Filling　充填 | | | | | |
| Core Building　支台築造　※Material素材（　） | | | | | |
| Metal Crown 金属冠　※Material素材（　） | | | | | |
| Jacket Crown ジャケット冠　※Material素材（　） | | | | | |
| Bridge Work　ブリッジ　※Material素材（　） | | | | | |
| Inlay　インレー　※Material素材（　） | | | | | |
| Plate Denture　有床義歯<br>Partial Denture　局部義歯<br>Complete Denture　総義歯 | | | | | |
| Periodontal Treatment　歯周治療 | | | | | |
| Medicine　投薬 | | | | | |
| The Others　その他 | | | | | |
| | | | | Total　合計 | |

Name and Adress of Attending Physician
担当医の名前及び住所

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

Medical Institution Name（医療機関名）：_____

Address(住所）：_____ Phone：_____

Date（日付）　：____.____.____　Signature（署名）_____