Form A

Attending Physician's Statement
診　療　内　容　明　細　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
   傷病名

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＿＿＿＿＿＿＿＿