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 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(裏面参照)

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 _____