Form A

# Attending Physician's Statement
# 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. 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 ____________

Form B

# Itemized receipt
# 領 収 明 細 書

| | | |
|---|---|---|
| (1) Fee for initial office visit | 初診料 | $ |
| (2) Fee for follow-up office visit | 再診料 | $ |
| (3) Fee for home visit | 往診料 | $ |
| (4) Fee for hospital visit | 入院管理料 | $ |
| (5) Hospitalization | 入院費 | $ |
| (6) Consultation | 診察費 | $ |
| (7) Operation | 手術費 | $ |
| (8) X-ray examination | X線検査費 | $ |
| (9) Medication | 医薬費 | $ |
| (10) Anesthetics | 麻酔費 | $ |
| (11) Operating room charge | 手術室費用 | $ |
| (12) Others(specify) | その他(項目明記) | $ $ |
| (13) Total | 合　計 | $ |

Important：Exclude the amount irrelevant to the treatment,I-e,extra charge for a bed.
注　意：高級室料等治療に直接関係のないものは除いて下さい。

Name and Address of Attending Physician／Superintendent of Hospital or Clinic
担当医又は病院事務長の名前及び住所

Name
名前 : Last 姓 First 名 Title 称号

Address : Home 自宅 Phone 電話
住所 Office 病院又は診療所 Phone 電話

Date : Signature
日付 署名