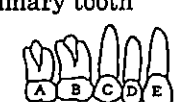


Request to Attending Physician  
担当医へのお願い

Form C  
様式C

1. Please fill in this form 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. 各月毎、また入院・入院外毎につき、この様式1枚が必要です。

Attending Dentist's Statement  
歯科診療内容明細書

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                       |  |                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------|--|---------------------------------|--|
| 1. Name of Patient (Last, First)<br>患者名 _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Age (Date of birth)<br>年齢(生年月日) _____                 |  | Sex (Male · Female)<br>性別 _____ |  |
| 2. Date of first Diagnosis<br>初診日 _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 3. Days of Diagnosis and Treatment<br>診療日数 _____ days |  |                                 |  |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Permanent tooth</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>(Upper)</p>  </div> <div style="text-align: center;"> <p>(Lower)</p>  </div> </div> </div> <div style="width: 45%;"> <p>Primary tooth</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>(Upper)</p>  </div> <div style="text-align: center;"> <p>(Lower)</p>  </div> </div> </div> </div> |  |                                                       |  |                                 |  |

Type of Treatment 治療の分類

| Dental Treatment<br>歯科治療                   | Localization of Teeth 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                  |                                        |      |     |     |            |
| Dental Pulp Extirpation 抜髄                 |                                        |      |     |     |            |
| Operation 手術                               |                                        |      |     |     |            |
| Extraction 抜歯                              |                                        |      |     |     |            |
| Filling 充填                                 |                                        |      |     |     |            |
| Inlay インレー                                 |                                        |      |     |     |            |
| Metal Crown 金属冠                            |                                        |      |     |     |            |
| Post Crown 継続歯                             |                                        |      |     |     |            |
| Jacket Crown ジャケット冠                        |                                        |      |     |     |            |
| Bridge Work ブリッジ                           |                                        |      |     |     |            |
| Plate Denture 有床義歯                         |                                        |      |     |     |            |
| Partial Denture 局部義歯                       |                                        |      |     |     |            |
| Complete Denture 総義歯                       |                                        |      |     |     |            |
| Treatment of Pyorrhea Alveolaris<br>歯槽膿漏処置 |                                        |      |     |     |            |
| Medicine 投薬                                |                                        |      |     |     |            |
| The Others その他                             |                                        |      |     |     |            |
| Total 合計                                   |                                        |      |     |     |            |

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

Name Last(姓) \_\_\_\_\_ First(名) \_\_\_\_\_ Title(称号) \_\_\_\_\_  
 Address Home(自宅) \_\_\_\_\_ Phone(電話) \_\_\_\_\_  
 Office(病院または診療所) \_\_\_\_\_ Phone \_\_\_\_\_

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 \_\_\_\_\_

様式C 邦訳

| Permanent tooth |  | Primary tooth |  |
|-----------------|--|---------------|--|
| (Upper)         |  | (Lower)       |  |
| (RIGHT)         |  | (LEFT)        |  |

治療の分類

| 歯科治療                | 患歯部位 | 日付 |   |   | 治療費 |
|---------------------|------|----|---|---|-----|
|                     |      | 月  | 日 | 年 |     |
| 初診料                 |      |    |   |   |     |
| レントゲン検査             |      |    |   |   |     |
| 抜髄                  |      |    |   |   |     |
| 手術                  |      |    |   |   |     |
| 拔牙                  |      |    |   |   |     |
| 充填                  |      |    |   |   |     |
| インレー                |      |    |   |   |     |
| 金属冠                 |      |    |   |   |     |
| 継続歯                 |      |    |   |   |     |
| ジャケット冠              |      |    |   |   |     |
| ブリッジ                |      |    |   |   |     |
| 有床義歯<br>局部義歯<br>総義歯 |      |    |   |   |     |
| 歯槽膿漏処置              |      |    |   |   |     |
| 投薬                  |      |    |   |   |     |
| その他                 |      |    |   |   |     |
| 合計                  |      |    |   |   |     |

翻訳者

住所

氏名

印

電話