Attending Physician's Statement

診療内容明細書

1	•	Name of Patient (Last・First) 患者名	_	
2	•	Name of Illness or Injury prefer Diseases for the use National H 傷病名及び国民健康保険用国際疫	ealth Insurance (refer to	attached paper 1)
3	•	Date of First Diagnosis: _ 初診日 _	D / M / Y 日 / 月 / 年	/
4	•	Duration of Treatment: 診療日数	days 日	
5	•	Out patient or Home Visit:		/ / 日間)
		Nature and Condition of Illness 症状の概要		
7	•	Prescription, Operation and Any 処方、手術その他の処置の概要	other treatment (in brie	ef)
8	•	Was the treatment required as a 治療は事故の傷害によるものです		njury? Yes No はい いいえ
9	•	Itemized Amounts paid to Hospi 治療実費	tal and / or Attending Pl	nysician:Form B 様式B
10	٠.	Name and Address of Physician 担当医の名前及び住所		
		Name名前 : <u>Last姓</u>	First名	Title称号
		Address住所 : <u>Home自宅</u>		Phone電話
		<u>Office病院</u>	又は診療所	Phone電話
		Date 日付:	Signature 署	
		Ref	erence Number of your N 診療録の番号	Attending Physician 担当医 Medical Record (if applicable)