

**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 \_\_\_\_\_

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 \_\_\_\_\_ First \_\_\_\_\_ Title \_\_\_\_\_  
姓 名 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