

Request to Attending Physician
担当歯科医へのお願い

- 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。
- This form should be completed and signed by the attending physician
この様式は担当医が記入し、かつ署名して下さい。
- One form for each month, one form for hospitalization / outpatient (home visit) should be filled out.
各月毎、入院・入院外毎に、この様式1枚が必要です。

Attending Physician Statement
歯科診療内容明細書

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. Date of first Diagnosis 初診日	
Days of Diagnosis and Treatment 診療日数	_____ days

3. teeth Number 歯式																																																																																																																							
Permanent Tooth 永久歯	Milky Tooth 乳歯																																																																																																																						
<table style="width: 100%; border-collapse: collapse;"> <tr> <td>#1</td><td>#2</td><td>#3</td><td>#4</td><td>#5</td><td>#6</td><td>#7</td><td>#8</td> <td>#9</td><td>#10</td><td>#11</td><td>#12</td><td>#13</td><td>#14</td><td>#15</td><td>#16</td> </tr> <tr> <td>R</td><td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> <td>L</td> </tr> <tr> <td></td><td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td> <td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> <td></td> </tr> <tr> <td></td><td>#32</td><td>#31</td><td>#30</td><td>#29</td><td>#28</td><td>#27</td><td>#26</td><td>#25</td> <td></td><td>#24</td><td>#23</td><td>#22</td><td>#21</td><td>#20</td><td>#19</td><td>#18</td><td>#17</td> <td></td> </tr> </table>	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15	#16	R	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	L		8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8			#32	#31	#30	#29	#28	#27	#26	#25		#24	#23	#22	#21	#20	#19	#18	#17		<table style="width: 100%; border-collapse: collapse;"> <tr> <td>#A</td><td>#B</td><td>#C</td><td>#D</td><td>#E</td> <td>#F</td><td>#G</td><td>#H</td><td>#I</td><td>#J</td> </tr> <tr> <td>R</td><td>E</td><td>D</td><td>C</td><td>B</td><td>A</td> <td>A</td><td>B</td><td>C</td><td>D</td><td>E</td> <td>L</td> </tr> <tr> <td></td><td>E</td><td>D</td><td>C</td><td>B</td><td>A</td> <td></td><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td> </tr> <tr> <td></td><td>#T</td><td>#S</td><td>#R</td><td>#Q</td><td>#P</td> <td></td><td>#O</td><td>#N</td><td>#M</td><td>#L</td><td>#K</td> </tr> </table>	#A	#B	#C	#D	#E	#F	#G	#H	#I	#J	R	E	D	C	B	A	A	B	C	D	E	L		E	D	C	B	A		A	B	C	D	E		#T	#S	#R	#Q	#P		#O	#N	#M	#L	#K
#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15	#16																																																																																																								
R	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	L																																																																																																						
	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8																																																																																																						
	#32	#31	#30	#29	#28	#27	#26	#25		#24	#23	#22	#21	#20	#19	#18	#17																																																																																																						
#A	#B	#C	#D	#E	#F	#G	#H	#I	#J																																																																																																														
R	E	D	C	B	A	A	B	C	D	E	L																																																																																																												
	E	D	C	B	A		A	B	C	D	E																																																																																																												
	#T	#S	#R	#Q	#P		#O	#N	#M	#L	#K																																																																																																												
Name of Illness 傷病名																																																																																																																							
1. Dental Caries 虫歯 2. Missing Teeth 欠損 3. Periodontal Diseases 歯周病 4. The Others その他 ()																																																																																																																							

Services 診療内容	Tooth No. 歯式	Fee 料金	Services 診療内容	Tooth No. 歯式	Fee 料金
(1) Examination 診察			(8) Filling Amal. ① surf. 面		
(2) X-ray レントゲン診断			充填 アマルガム ② surf.		
Bite-wings 咬翼型 ×			③ surf.		
Periapical 標準型 ×			Filling Comp. ① surf. 面		
Panoramic パノラマ ×			充填 複合レジン ② surf.		
(3) Medication 投薬 ☐ Yes ☐ No			③ surf.		
(4) Prophylaxis / Scaling 歯垢 ← 歯垢除去			(9) Inlay / Onlay インレー・アンレー		
Fluoride フッ化物塗布			(10) Amal. / Comp. Build-up		
(5) Extraction 抜歯			充填物による支台築造		
(6) Periodontal Scaling / Root planing			Post & Core メタルコア		
歯肉下歯石除去・根面平滑化			(11) Crown 冠		
Gingival Curettage 盲嚢搔爬			Porcelain / Gold ポーセレン・金		
(7) Pulp Cap 歯髄覆罩			Silver Alloy 銀合金		
Pulpotomy 歯髄切断・抜髄			(12) Bridge Work ブリッジ		
Root Canal Therapy 根管治療			Abutment 支台歯		
① Canal 根管			Pontic ポンティック		
② Canal			(13) Plate Denture 有床義歯		
③ Canal			(14) Other その他		
			Total Fee 合計		

4. Name and Address of Attending Physician 医師の氏名及び医院の名称及び所在地		Unit is 通貨単位
Name 名前: Last 姓	First 名	
Address: Home (自宅)		Phone
Office (病院又は診療所)		Phone
Date 日付	Attending Physician Signature 医師の署名	