Request to Attending Physician
担当医へのお願い

1. Please fill in this form so that the patient may claim the social insurance benefit.
   この様式は患者の社会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書き、かつ署名をして下さい。
3. One form for each month and one form for hospitalization/outpatient (home visit) should be filled out. 各月毎、入院･入院外毎に付、この様式1枚が必要です。

Form C
(様式C)

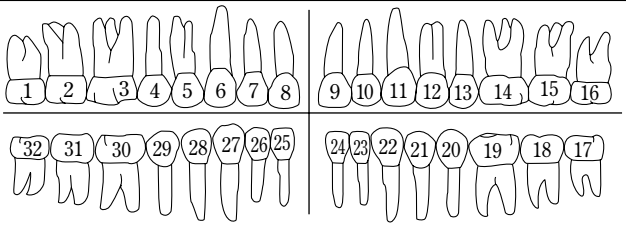
Attending Dentist's Statement
(歯科診療内容明細書)

Name of patient (Last, First) (患者名)_____ Age (Date of Birth) 年令(生年月日) _____ Sex (Male・Female) 性別(男・女)

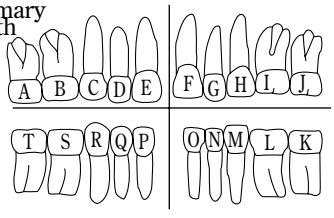
Date of First Diagnosis(初診日): _____ 20_____

Days of Diagnosis and Treatment(診療日数): _____ days

Permanent tooth (Upper) (Lower) (RIGHT) (LEFT)



Primary tooth (RIGHT) (LEFT)



Tooth No. or Letter	Description of Service (Including X-Rays. Prophylaxis. Materials used. ETC.)	Date MO.	Date DA.	Date YR.	Amount
				Total Amount	

Name and Address of Attending Dentist
(担当医の名前及び住所)

Name : Last (姓) _____ First (名) _____

Address : Home (自宅) _____ Phone _____

Office (病院又は診療所) _____ Phone _____

Date : _____ Signature (署名) _____

Attending Dentist (担当医)

Reference Number of your Medical Record (if applicable)
(診療録の番号) _____