

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

1. Please fill in this form so that the patient may claim the National Health insurance benefit.
この様式は患者の国民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 is to be completed and signed by the attending dental surgeon.
この様式は担当歯科医が記入し、署名してください。

3. One form for each month and one 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。

Form C (様式C)

RECEIPT (DENTAL) 領収明細書 (歯科)

Name of Patient (Last, First) 受診者名		Age (Date of Birth) 年齢	Sex (Male・Female) 性別	
Date of First Diagnosis 初診日		Days of Diagnosis And Treatment 診療実日数 _____ days		
Localization of Teeth 部位				
Permanent Tooth 永久歯 (F) 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		Deciduous Teeth 乳歯 (F) e d c b a a b c d e (L) e d c b a a b c d e		
1. Name of Illness 傷病名				
(1) Dental Caries う蝕症 _____		(2) Missing Tooth 欠損 _____		(3) Pyorrhea Alveolaris 歯槽膿漏 _____
(4) Extraction Needed 抜歯 _____		(5) The Others その他 _____		
2. Dental Treatment		Localization of Teeth Examined 患歯部位	Material 材料	Fee 治療費
歯科治療				
(1) Initial Office Visit (初診料)				
(2) Office Visit Fees (再診料)				
(3) Days of Diagnosis and Treatment (診療実日数)				
(4) Examination Fees (検査料)				
(5) X-Ray Examination (レントゲン検査)				
dental 単純撮影 (標準 or デジタル)				
panorama パノラマ撮影 (標準 or デジタル)				
(6) Dental Pulp Extirpation (抜髄)				
(7) Operation (手術)				
(8) Extraction (抜歯)				
(9) Filling (充填)				
(10) Inlaying (インレー又はアンレー)				
(11) Metal Crown (金属冠)				
(12) Post Crown (継続歯)				
(13) Jacket Crown (ジャケット冠)				
(14) Bridge Work (ブリッジ)				
(15) Plate Denture (有床義歯)				
(16) Partial Denture (局部義歯)				
(17) Complete Denture (総義歯)				
(18) Treatment of Pyorrhea Alveolaris (歯槽膿漏)				
(19) Medicine (投薬)				
(20) The Others (その他)				

the currency unit (通貨単位) Total (合計) _____

Name of Dental Surgeon 医師名 _____

Name and Address of Dentist's Office
医師の名称・住所 _____

Date 日付 _____