※ この明細書は海外で診療を受けた医師に記入してもらって下さい。
なお、申請の際には、別紙に和訳と翻訳者・氏名・印をお願いします。

1. This form is used for claiming the social insurance benefit.
(この様式は社会保険の給付の申請に使用されます。)
2. This form should be completed and signed by the attending dentist.
(この様式は担当医が書き、かつ署名して下さい。)
3. One form for each month, one form for hospitalization/outpatient and home visit.
(各月毎、入院・入院外毎に付この様式1枚が必要です。)

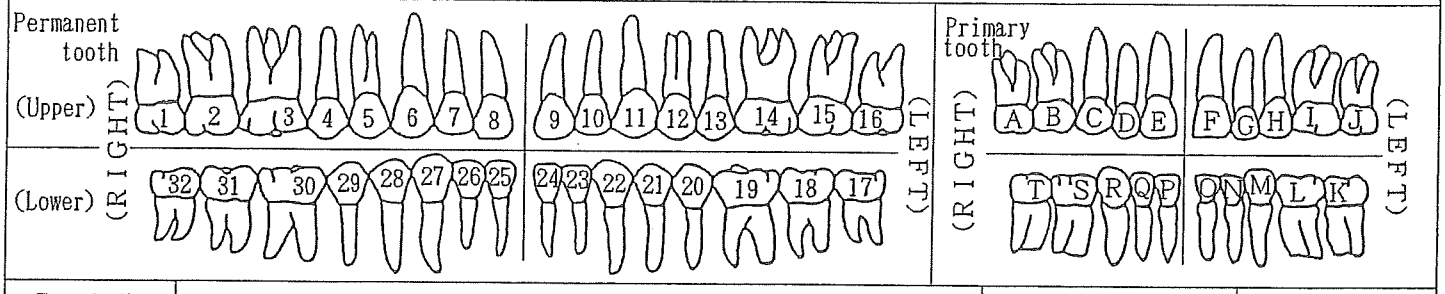
Form C
様式 C

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) 年齢 (生年月日) _____ Sex (Male · Female) 性別 (男・女)

Date of First Diagnosis (初診日) : ___/___/___ Name of Illness (傷病名) : _____

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



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) _____