

別紙様式第6号

RECEIPT (DENTAL)

(領収明細書 (歯科))

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 physician.
この様式は担当医が書き、かつ署名して下さい。
3. Separate receipt required for prescriptions.
薬剤料は別に処方箋を添附のこと。
4. DAYS OF DIAGNOSIS AND TREATMENT and PAYMENT should be monthly filled out when treatment extends for two month period.
治療が次の月に亘る時は、診療日数・支払い金額を月別に記入して下さい。

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)

Permanent (疾病の名称および部位)		Baby teeth (乳歯)																																																																																																																																																																						
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Identify examined teeth: (該当する部位を○でかこみ病名をつける)																																																																																																																																																																								
cavity (C) (むし歯)		pyrrhea al veolaris (P) (歯槽膿漏)																																																																																																																																																																						
missing teeth (F) (欠歯)		extraction needed (Z) (要抜歯)																																																																																																																																																																						
stomatitis (G) (口内炎)																																																																																																																																																																								
Examination fees (診断料)	first examination (初診日)	Days of Diagnosis and Treatment (診療日数)	days (日)																																																																																																																																																																					
		<table border="1"> <tr><th colspan="31">MARK THE DATE PATIENT RECEIVED TREATMENT</th></tr> <tr><th>MONTH</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th><th>9</th><th>10</th><th>11</th><th>12</th><th>13</th><th>14</th><th>15</th><th>16</th><th>17</th><th>18</th><th>19</th><th>20</th><th>21</th><th>22</th><th>23</th><th>24</th><th>25</th><th>26</th><th>27</th><th>28</th><th>29</th><th>30</th><th>31</th><th>/</th></tr> <tr><td>()</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><th>MONTH</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th><th>9</th><th>10</th><th>11</th><th>12</th><th>13</th><th>14</th><th>15</th><th>16</th><th>17</th><th>18</th><th>19</th><th>20</th><th>21</th><th>22</th><th>23</th><th>24</th><th>25</th><th>26</th><th>27</th><th>28</th><th>29</th><th>30</th><th>31</th><th>/</th></tr> <tr><td>()</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>	MARK THE DATE PATIENT RECEIVED TREATMENT																															MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	/	()																																		MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	/	()																																		
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Payment (支払金額)																																																																																																																																																																								
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Examination fees (検査料)	X-ray fee (レントゲン)	other (その他)																																																																																																																																																																						
Services (治療した歯の部位と治療の種類) (Describe when gold, platinum or porcelain was used (治療材料に金、白金、陶歯 (ポーセリン) を使用したときは特記して下さい))																																																																																																																																																																								
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◦ inlaying (インレー又はアンレー)																																																																																																																																																																								
◦ capping (metal)																																																																																																																																																																								
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◦ capping connected (歯冠継続歯)																																																																																																																																																																								
◦ hiped Teeth (欠損歯を補綴した場合その部位と種類)																																																																																																																																																																								
◦ bridge (ブリッジ)																																																																																																																																																																								
◦ partial artificial teeth (局部義歯)																																																																																																																																																																								
◦ total artificial teeth (総義歯)																																																																																																																																																																								
Total (計)																																																																																																																																																																								
Currency (unit) 通貨単位																																																																																																																																																																								

Name and Address of Attending Physician

担当医の名前及び住所

Name 名前: Last 姓

First 名

Name of Hospital or Clinic (病院又は診療所名)

Address 住所 Office 病院又は診療所

Phone

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