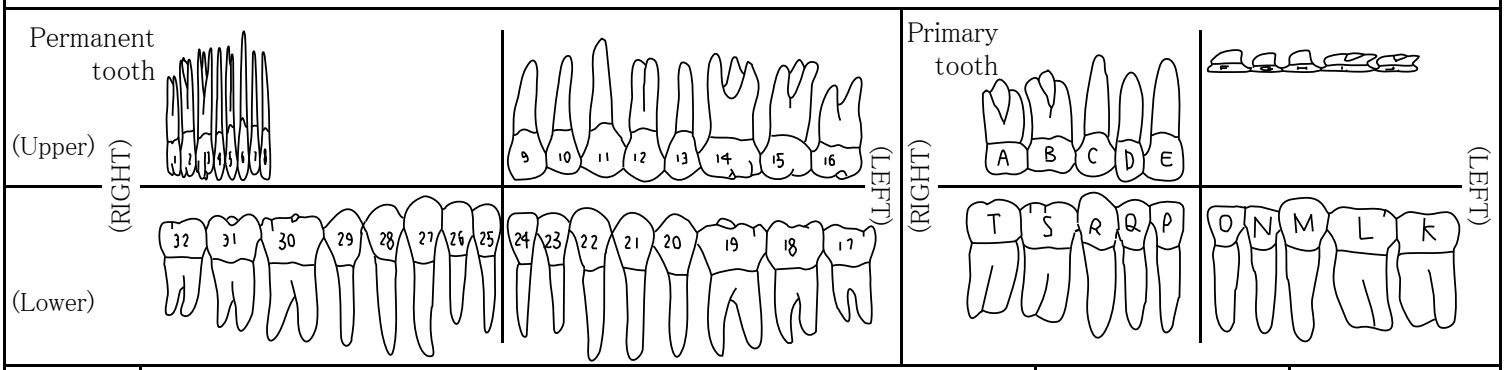
Form C
様式C

1. This form 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, one form for hospitalizaton/outpatient and home visit.
   (各月毎、入院・入院外毎に、この様式1枚が必要です。)

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



Tooth No. of 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 (電話) _____

Office(病院又は診療所) _____ Phone (電話) _____

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) _____