Attending Physician's Statement (診療内容明細書)

This form is used for claiming the social insurance benefit

Name of Patient (受診者名) Age(年令) Sex(男、女) Male,Female

First Diagnosis(初診日) Days of Diagnosis and Treatment (診療日数) days

Localization of Teeth(部位)

Permanent Teeth(永久歯)

	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
R																L
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Deciduous Teeth (乳歯)

	E	D	C	B	A		A	B	C	D	E
R										L
	E	D	C	B	A		A	B	C	D	E

Dental Treatment		Date	Localization of Teeth Examined & Material	Unit fee	Amount fee
＊Examination/Consultation					
＊X-Ray Examination(Panoramic, Intraoral, Bitewing)					
＊Scaling & Polishing/Prophylaxis					
＊Topical Fluoride Application					
＊Restration	@Amalgam Simple/ Complex				
	@Light Cured Resins Simple/ Complex Bonding/titanium screws				
	@Crown Ordinary/with pin core /with root post core				
	@Bridge				
＊Root Canal Therapy (single,double,multi)					
＊Periodontics(Curettage ; Root Plan & Scaling)					
＊Extraction (Routine/difficult)					
＊Oral Surgery @Impacted Teeth @Apicoectomy @Periodontal Surgery @Others					
＊Partial Dentures(Acrylic,Chrome Cobalt, Others)					
＊Complete Dentures(Acrylic,Chrome Cobalt, Others)					
＊Orthodontic Treatment					
＊Medication					
＊Others					
			Total		

Date

Name of Dental Surgeon Signature

Name and Address of Dentist's Office