様式第18号の5（第37条関係）

　　(歯科)　　　　　　　　　　　　診療内容証明書

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 診療期間　自　　　　年　　月　　日  　　　　　至　　　　年　　月　　日 | 保険者名 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | 被保険者氏名 | | | | | | | | | | | | | | | (　歳) | | | | | | 性別 | 男 | |
| 傷病名部位 | 1  2 | | | | | | | | | | | | | | | | | | | | | | | | | | | 女 | |
| 診療開始日 | | | | | | | | | | | | | | | 1　　　年　　月　　日  2　　　年　　月　　日 | | | | 実日数 | | 日 | | |
| 初診 | 時間外　　　　　深夜 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | 摘要 | | | | | | |
| 投薬 | 内服｛ | | | | | ×　　単位  ×　　単位 | | | | | | | | | | | | | | | 内服  屯服 | | | | | | | | | | | | ×  × | | | | | | | | | |  | 点 |  | | | | | | |
| 屯服 | | | | | ×　　単位 | | | | | | | | | | | | | | |
| 注射 | 皮下(筋)  静脈 | | | | | | ×  × | | | | | | | | | | | | | | 皮下(筋)  静脈 | | | | | | | | | | | | ×  × | | | | | | | | | |  |  |
| ゲン  レント | 診断　　　回  (50/100)　回 | | | | | | | | | | 撮影　　　回  (50/100)　回 | | | | | | | | | | | | | | | | | | 標準 | | | | | | | 枚  枚 | | | | | | |  |  |
| 処置 | 普通処理  (複) | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 回  回 |  |  |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| 抜髄(単)　　回 | | | | | | | | | | | | (複)　　　回 | | | | | | | | | | | | | | | | | | | 切断　　回 | | | | | | | | | | |  |  |
| 根充(単)　　　　回 | | | | | | | | | | | | | | | | | | | (複)　　　　　　回 | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 特定薬剤 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 軟組織処置 | | | | ×　　回 | | | | | | | | | | | | | | 外科後　　×　　回  処置　　×　　回 | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 特定薬剤 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 歯石除去　　　　回 | | | | | | | | | | | | | | | | | | | 膿漏処置　　　　回 | | | | | | | | | | | | | | | | | | | | | | |  |  |
| その他 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 特定薬剤 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 除去　　　　　　回 | | | | | | | | | | | | | | | | | | 調整(研磨)　　　回 | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| インフレー  充てん | ア | ×　　回  ×　　回 | | | | | | | | | | | | | | | | | レ | | | | | ×　　回  ×　　回 | | | | | | | | | | | | | | | | | | |  |  |
| 硅 | ×　　回  ×　　回 | | | | | | | | | | | | | | | | | 燐 | | | | | ×　　回  ×　　回 | | | | | | | | | | | | | | | | | | |  |  |
| 14Kポスト | | | 個 | | | | | | | 14K複雑 | | | | | | | | 個 | | | | | | | | | | その他の合金 | | | | | | | | 個 | | | | | |  |  |
| 補 | 義歯 | | | | | | | 床　　　　　　　歯 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| クラスプ | | | | | | | 14K | 個 | | | | | 不  特 | | 双 | | | | | | 個 | | | 不  特 | | | レスト  個 | | | | | | | 不  特 | | | | | ナシ  個 | | |  |  |
| バー | | | | | | | 特殊　　　個 | | | | | | | | | | | | | | | | | 不銹 | | | | | | | | | | | | | | | | | |  |  |
| 歯冠継続歯 | | | | | | | 14K | 個 | | | | | その他の合金 | | | | | | | | | | | 個 | | | | | | 陶  個 | | | | | | | レ  個 | | | | |  |  |
|  | てつ | 支台築造 | | | | | | | セ　個 | | | | | | | | | | ア　個 | | | | | | | | | | | | | その他の合金 | | | | | | | | | | 個 | |  |  |  | | | | | | |
| 金属冠 | | | | | | | 金 | | 大  小 | | 個 | | | | | | パ  ラ | | | | | 大  小 | | | 個 | | | | | その他の合金 | | | | | | | | | | 個 | |  |  |
| ダミー | | | | | | | 前 | | 14Kレンジ  その他の合金 | | | | | | | | | | 個 | | | | | | 白 | | | | パラ  その他  の合金 | | | | | | | | | | | 個 | |  |  |
| その他 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 手術 | 抜歯 | | | | | | | 乳歯 | | | | | | | 前歯 | | | | | | | | | | | | 臼歯 | | | | | | | | 難歯 | | | | | | | |  |  |
| その他 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 特殊薬剤 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 麻酔 | 伝麻　回 | | | | | | | 浸麻　回 | | | | | | | | | 迷もう　回 | | | | | | | | | | | | | | | | | 全麻　回 | | | | | | | | |  |  |
| その他 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
| 食事療養  (入院期間) | | | | | | | | 年　　月　　日から  　　年　　月　　日まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 日間 | | | | 円 | |
| 合計 | 療養の給付 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | 点 | 決定 | 療養の給付 | |  | | | 点 |
| 食事療養 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 円 | | 食事療養 | | 円 | | | |
| (標準負担額) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 円 | |  | | | | | | |
| 薬剤一部負担金額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 円 | |
| 上記のとおり証明いたします。  　　保険医療機関等の名称  　　　　　　年　　月　　日  所在地  氏名　　　　　　　　　　印 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |