Case report　（No. 1 -10 in order）

　　　　　　　Applicant　　　　　○○　○○　　　　　　　seal

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial letters of the name　（sex） | Institution | Date at the first visit  （Age at the time） | Treatment period.  （Age during the period） | Systemic diseases, developmental disorders, etc. |
| Ｔ.H. (male) | Dept. of Pediatric Dentistry,  ○○University | 2002.7.8 (4y10m) | 2016.4.8〜2018.12.25  (5y7m〜11y3m) |  |
| **Summary**  Background of patients at the first visit:  Oral condition at the first visit in detail:  Main complaint at the first visit and the diagnosis:  Treatment plan  Process and contents of the treatments in detail:  Results and prognosis derived from the long-term treatment:  ※　１　Make copies of this form and use them for case No.1-10.  ※　 ２　 Print all the case reports on A4 paper after fill in the form. (Figures can be inserted).  ※　 ３　 Formats including margins and ruled line positions cannot be changed (character size can be changed).  ※　４　 Submit all the printed forms with signature of the facility director. | | | | |

I prove that there is no fault about the contents above.

　　Name of medical institution/facility 　　 Pediatric Dentistry of ○○University Hospital

　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　Director　　　　○○　○○

　　（In the case of multiple medical institutions, the signature of each institutional director is required.

If the applicant is the director, applicant's own signature is acceptable.）

Case report（No. 　　）

　　　　　Applicant

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial letters of the name　（sex） | Institution | Date at the first visit  （Age at the time） | Treatment period.  （Age during the period） | Systemic diseases, developmental disorders, etc. |
|  |  |  |  |  |
| **Summary**  Background of patients at the first visit:  Oral condition at the first visit in detail:  Main complaint at the first visit and the diagnosis:  Treatment plan  Process and contents of the treatments in detail:  Results and prognosis derived from the long-term treatment: | | | | |

I prove that there is no fault about the contents above.

　　Name of medical institution/facility .

　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　Director .

　　　（In the case of multiple medical institutions, the signature of each institutional director is required.

If the applicant is the director, applicant's own signature is acceptable.）