



Visiting Patient Demographics Form

Preferred DCL Location: _____ (Not a guarantee) Date: _____/_____/_____

Dates you would like to visit: _____ (THESE MUST BE CONFIRMED)

Reason for visit: _____

Patient Name: _____

_____ *Last* *First* *Middle*

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Address: _____

_____ *Street* *City* *State* *Zip*

Phone Number: (_____) _____ Other Phone: (_____) _____

Marital Status: _____ Spouse Name: _____

Employment Status (Please circle one): Part Time Full Time Medical Leave Disabled Retired (mo/yr) _____

Employer's Name and Address: _____

Name and Address of your facility: _____

Facility Phone Number: (_____) _____ Facility Fax Number: (_____) _____

First Date of Dialysis (FDOD): _____/_____/_____

Next of Kin:

Name: _____ Relationship to patient: _____

DialysisCenterofLincoln.org

O St.
402.489.5339
7910 O St.
Lincoln, NE 68510

Northwest
402.438.7330
3211 Salt Creek Cir.
Lincoln, NE 68504

Southwest
402.742.8500
5355 S. 16th St.
Lincoln, NE 68512

Columbus
402.563.2139
2452 39th Ave.
Columbus, NE 68601

Home Dialysis
402.742.8500
5355 S. 16th St.
Lincoln, NE 68512



Address: _____

Street *City* *State* *Zip*
Phone Number: (_____) _____ Other Phone:
(_____) _____

Nebraska area contact person to notify in case of emergency:

Name: _____ Relationship to
patient: _____

Address: _____

Street *City* *State*
Zip
Phone Number: (_____) _____ Other Phone:
(_____) _____

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