

Select the appropriate office location

San Jose/Los Gatos
2420 Samaritan Drive
San Jose, CA 95124

Mountain View
525 South Drive, Suite 115
Mountain View, CA 95040

San Jose / O'Connor
2100 Forest Avenue, Suite 103
San Jose, CA 95128

Saratoga
18988 Cox Avenue Suite B
Saratoga, CA 95070

Los Altos
129 Fremont Avenue
Los Altos, CA 94022

Monterey/Ryan Ranch
9781 Blue Larkspur Lane, St Suite 100
Monterey, CA 93940

San Mateo
136 North San Mateo Drive, 2nd Floor
San Mateo, CA 94401

San Francisco Lauriel Heights
3905 Sacramento Street Suite 201
San Francisco, CA 94118

San Francisco Pacific Heights
2100 Webster Street, Suite 318
San Francisco, CA 94115

Salinas
559 Abbott Street, Suite A
Salinas, CA 93901

Santa Cruz County
204 Green Valley Road
Freedom, CA 95019

Monterey
977B Pacific st
Monterey, CA 93940

South San Jose
393 Blossom Hill Road, Suite 290
San Jose, CA 95123

Daly City
1800 Sullivan Avenue, Suite 403
Daly City, CA 94015

Castro Valley
20055 Lake Chabot Rd Ste 150
Castro Valley, CA 94546

If patient is a minor*, the parent or legal guardian must read, complete and sign the following form:

This form is required to allow us to evaluate, treat and bill for medical goods and services provided to a minor.

I consent to having California Skin Institute conduct examinations and perform procedures as are medically required and administer treatment and medications as deemed necessary or advisable to the minor* child noted below.

I am an adult who is the:

Parent

Mother

Father

Printed Name of Parent/Guardian

Legal Guardian

Guardian

Contact Telephone Number

In my absence, I consent to having California Skin Institute conduct examinations and perform procedures as are medically required and administer treatment and medications as deemed necessary or advisable to the minor* child noted below.

I would:

Like

Not Like

to be consulted prior to minor procedures such as mole removal, acne treatment and wart treatment.

Patient or Responsible Party's Signature:

Date Signed

Minor Child/Patient's Printed Name:

Patient's Age *

Witness Signature:

Date Signed

Witness Printed Name:

* Under 18 years of age