Patient Information Submission

Date: **[Insert Date]**

To Whom It May Concern,

I am submitting my patient information in relation to my weight loss surgery application. Please find the required details below:

Personal Information

- **Full Name:** [Insert Full Name]
- **Date of Birth:** [Insert Date of Birth]
- **Address:** [Insert Address]
- **Phone Number:** [Insert Phone Number]
- **Email:** [Insert Email]

Medical History

[Brief description of medical history and relevant conditions]

Current Weight and Height

- **Weight:** [Insert Weight]
- **Height:** [Insert Height]

Previous Weight Loss Attempts

[Brief description of previous attempts at weight loss]

Other Relevant Information

[Any additional information pertinent to the application]

Thank you for considering my application. If you require any further information, please do not hesitate to contact me.

Sincerely,

[Insert Your Name]

[Insert Your Signature if sending a hard copy]