

# COE Personal Questionnaire

Patient:

Family Dr:

Print date :

Created on :

Updated on :

- 
- | Yes | No  | Question  |
|-----|-----|---|
| [ ] | [ ] | 1. What do you most look for in a dental office?<br>.....   |
| [ ] | [ ] | 2. What are your GOALS for your dental health?<br>.....   |
| [ ] | [ ] | 3. How do you feel about your smile?<br>.....   |
| [ ] | [ ] | 4. What are some things about your smile that you would like improved?<br>.....                     |
| [ ] | [ ] | 5. On a scale of 1 to 10, how would you rate your level of anxiety about dental treatment?<br>..... |
| [ ] | [ ] | 6. Tell me about your past dental experiences:<br>.....   |
| [ ] | [ ] | 7. What if, anything, in the past has kept you from having dental treatment?<br>.....               |
| [ ] | [ ] | 8. How important do you think your dental health is in your elder years?<br>.....                   |
| [ ] | [ ] | 9. On a scale of 1 to 10, how would you rate your dental health today?<br>.....                     |
| [ ] | [ ] | 10. How so?<br>.....  |