

Harbourside Dental Group

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Dental Benefit Worksheet

Plan #1: Company Name: _____

Group#: _____ ID/Certificate#: _____

Plan Holder: _____ D.O.B.: _____

A (Basic): _____ B (Major): _____ Plan C (Ortho): _____ Deductible: _____

Annual Max: _____ Benefit year: _____

Plan Eligibility:

Units Scaling/Root Planing: _____

Recall frequency: _____

Composites on Molars: _____

Onlays/Inlays: _____

Plan #2: Company Name: _____

Group#: _____ ID/Certificate#: _____

Plan Holder: _____ D.O.B.: _____

A (Basic): _____ B (Major): _____ Plan C (Ortho): _____ Deductible: _____

Annual Max: _____ Benefit year: _____

Plan Eligibility:

Units Scaling/Root Planing: _____

Recall frequency: _____

Composites on Molars: _____

Onlays/Inlays: _____