CLAIMANT CONTACT INFORMATION

Name: Raye Manuele Robinson
Address: 5704 W. Walker St.
W. Allis, WI 53214

Phone: 414-534-9596
Email: raye@onerobinsonfamily.com

INSTRUCTIONS

Complete this form, print and sign it, and serve a hard copy upon the West Allis City Clerk. If you have questions about how to fill out this form, please contact a private attorney who can assist you.

NOTICE OF CLAIM

Date of incident: 4-8-26
Time of day: 11:00 am
Location: 946 S. 57th St. W. Allis, WI 53214

Describe the circumstances of your claim here. You may attach additional sheets or exhibits. Some helpful information may be the police report, pictures of the incident or damage, a diagram of the location, a list of injuries, a list of property damage, names and contact information for witnesses to the incident, and any other information relevant to the circumstances.

While walking north on 57th street my toe caught a raised slab of sidewalk, I did not notice it because of a tree shading it. I fell face forward and broke my two front teeth which the dentist had to rebuild, I notified the city and they have since put tar to fill in those raised slabs.

Check one:

[X] ..... I am seeking damages at this time (complete Claim Amount section below)
[ ] ..... I am submitting this notice without a claim for damages. This claim is not complete and will not be processed until I submit a claim for damages on a later date.

Signed: Raye Manuele Robinson
Date: 7-30-26

CLAIM AMOUNT

To complete this claim, attach an itemized statement of damages sought. If any damages are for repair to property, include at least 2 estimates for repairs.

The total amount sought is: $ 1165.65

SAVE PRINT

RECEIVED
JUL 31 2026
CITY OF WEST ALLIS

Eastbrook Dental

12660 W North Ave
Brookfield, WI 53005
(262)796-1312 (262)796-1312

April 27, 2026

Raye Manuele Robinson
5704 W. Walker St.
West Allis, WI 53214

ID: 1130

Account Aging	
Current:	$0.00
30 Days:	$0.00
60 Days:	$0.00
90 Days:	$0.00
Contract:	$0.00
Balance Due:	$0.00
Estimated Insurance:	$0.00
Balance Due Now:	**$0.00**

Date	Patient	Provider	Transaction	Tth	Surface	Fee
4/27/2026	Raye	Gabriel LeGros, DDS	D0220 - Intraoral Periapical Images	8		$52.00
4/6/2026	Raye	Gabriel LeGros, DDS	D0140 - Limited oral evaluation			$115.00
	Raye	Gabriel LeGros, DDS	D0230 - Intraoral-periapical each addl	8		$49.00
	Raye	Gabriel LeGros, DDS	D9215 - Local anesthesia	8		$69.00
	Raye	Gabriel LeGros, DDS	D2335 - Resin-4+ w/incis angle-anterior	8	MIFL	$471.00
	Raye	Gabriel LeGros, DDS	D2335 - Resin-4+ w/incis angle-anterior	9	MIFL	$471.00
4/27/2026	Raye		Acct Pmt - Check Number 6597 for ($1,165.65)			

SubTotal:	$1,227.00
Tax:	$0.00
Discount:	$61.35
Charge(s):	$1,165.65
- Payment(s):	$1,165.65
Balance Due:	$0.00

Contract Balance	Estimated Insurance	Previous Balance	Charge(s)	Payment(s)	Adjustment(s)	Balance Due Now
$0.00	$0.00	$0.00	$1,165.65	$1,165.65	$0.00	**$0.00**

Future Family Appointments: **None**

Patient:	Next Appointment:	Patient:	Next Appointment:	Patient:	Next Appointment:

Current Dental Terminology (CDT)